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Pepperdine University
Graduate School of Education and Psychology

THE MULTIDIMENSIONAL WELLBEING ASSESSMENT:
PRELIMINARY VALIDATION IN AN IRANIAN SAMPLE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Nicole Moshfegh

July, 2014

Shelly Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Nicole Moshfegh

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly Harrell, Ph.D., Chairperson

Susan Himmelstein, Ph.D.

Shereen Kianmahd, Psy.D.

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I would like to express my deepest gratitude to Dr. Shelly Harrell, who has inspired and nurtured my growth as a professional throughout my graduate career. Your dedication and mentorship have always served as a guiding light throughout the graduate process and beyond. Thank you for aiding me in accomplishing the task of completing my dissertation, as this would have never been possible without your never-ending support. Your commitment to the field of culture and mental health is truly admirable; I hope only to continue down the path you have led.

I would like to express my sincerest gratitude to Dr. Susan Himmelstein for sparking my interest in the field of assessment and providing me with the skills to build upon my burgeoning expertise in this field. Your dedication to your students is ever-apparent. I am forever thankful to have had the opportunity to learn from such an accomplished professional, as it has inspired my professional development and desire to pursue the field of assessment.

I would also like to thank Dr. Shereen Kianmahd for your knowledge and insight with which you contributed to this work. Your dedication to the profession of psychology and the Iranian community has paved the way for those who will follow your footsteps, as you serve as an exemplary role model for future Iranian psychologists.

Finally, I would like to thank my family and partner, whose endless support, love, and encouragement gave me the strength I needed to overcome any obstacle to cross my path. You are all the forces that drive me to succeed, providing me with the meaning and purpose necessary to nurture my growth in all capacities.

VITAE

Nicole Moshfegh, M.A.**Education**

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 Graduate School of Education and Psychology
- December 2009 **Mast of Arts, Psychology**
 Pepperdine University, Los Angeles, California
 Graduate School of Education and Psychology
- June 2008 **Bachelor of Arts, Psychology & Social Behavior**
 University of California, Irvine
- June-August 2007 **Education Abroad**
 Universidad Europea de Madrid
 Madrid, Spain

Clinical Experience

- July 2013 - Present **Psychology Intern**, University of California, Los Angeles (UCLA)
 David Geffen School of Medicine
 Department of Psychiatry and Biobehavioral Sciences
 Semel Institute for Neuroscience and Human Behavior &
 The Resnick Neuropsychiatric Hospital
 APA Accredited Pre-Doctoral Internship
Adolescent Serious Mental Illness Track:
- Provide individual and group therapy, case management, urgent care, and crisis intervention for youth coping with or at risk for serious mental illness
 - Conduct comprehensive psychodiagnostic assessments for youth with complicated clinical presentations with or at high risk for serious mental illness
 - Compile integrated clinical assessment reports, summarize findings, and make treatment recommendations at multidisciplinary team meetings
 - Determine eligibility for participation in a clinical research program for adolescents and young adults at risk for or with recent onset of psychosis, as part of the North American Prodrome Longitudinal Study, a consortium of eight independent NIMH funded prodromal studies across the nation
 - Develop and administer community outreach presentations for a variety of audiences, including community mental health clinics, school districts, and medical centers, with the goal of educating attendees on the early warning signs of psychosis and bipolar spectrum disorders and the benefits of early intervention
 - Attend weekly multidisciplinary treatment team, case conference meetings, seminars, didactics, and rounds on a variety of topics, including child and adolescent psychopathology/psychopharmacology

- Electives:
 - Child and Adolescent Mood Disorders Program:*
 - Provide short-term and long-term therapy for youth with or at high risk for psychosis, mood, or anxiety disorders utilizing family-focused therapy (FFT), cognitive behavioral therapy, and behavior management techniques
 - Adolescent Medicine Clinic:*
 - Evaluate, provide brief interventions, and triage adolescents presenting to an outpatient adolescent medicine clinic with a range of medical conditions, developmental abilities, and co-morbid psychosocial and/or mental health problems
 - Child OCD, Anxiety, and Tic Disorders Program:*
 - Perform structured assessments and conduct evidence-based treatments, including cognitive-behavioral therapy, for children and adolescents with OCD, anxiety, tic, and habit disorders

July 2012 -
June 2013

Neuropsychology Extern, Children's Hospital Los Angeles
Clinical Trials Unit
Supervisor: Sharon O'Neil, Ph.D., M.H.A.

- Conduct comprehensive neuropsychological and developmental evaluations with pediatric patients (birth-24 years old) with various medical diagnoses/disabilities, concussions, and traumatic brain injuries
- Interpret neuropsychological test data and write integrative reports, including remedial recommendations for parents, physicians, and educators
- Conduct medical chart reviews, school consultations, multidisciplinary consultations, and clinical feedback sessions
- Attend weekly pediatric grand rounds and adolescent medicine grand rounds and weekly neuropsychology didactics with topics including cultural and ethical issues in assessment, neuroanatomy, cognitive domains, stroke, brain tumors, etc.

July 2012 -
June 2013

Psychology Extern, Children's Hospital Los Angeles
Division of Plastic Surgery, Craniofacial and Cleft Center
Supervisor: Alessia Johns, Ph.D.

- Co-facilitate two separate, eight-week, parent and patient psychoeducational and support groups for patients ages 7 to 16 in the Division of Plastic Surgery, addressing social and coping skills, including activities such as role-playing
- Medical diagnoses included cleft lip/palate, genetic syndromes, microtia, vascular anomalies, and orthognathic disorders

July 2011 -
December 2012

Psychology Extern, University of California, Los Angeles (UCLA)
Semel Institute for Neuroscience and Human Behavior
Center for the Assessment and Prevention of Prodromal States (CAPPS)
Adolescent Brain and Behavior Research Clinic (ABBRC)
Supervisors: Carrie Bearden, Ph.D. & Peter Bachman, Ph.D.

- Conduct intake interviews and administer comprehensive clinical assessments to patients (ages 12-35) at high risk for or diagnosed with psychotic-spectrum diagnoses
- Administer, score, and interpret diagnostic assessments given to patients and their families, including SCID and SIPS

- Administer, score, and interpret comprehensive neuropsychological assessments
- Write integrated clinical and neuropsychological assessment reports and make treatment recommendations at weekly multidisciplinary team meetings
- Provide feedback, recommendations, and references for community resources to patients, family members, and referring clinicians
- Prepare case presentations for bi-weekly neuropsychology case conferences
- Assess and manage suicidal and homicidal ideation and behavior
- Co-lead intervention groups for youth with psychotic-spectrum disorders

September 2010 -
June 2013

Psychology Extern

Pepperdine University Psychological and Educational Clinic, Los Angeles, CA
Supervisors: Aaron Aviera, Ph.D. & Shelly Harrell, Ph.D.

- Conduct diagnostic interviews and intakes with adult clients, including risk assessment
- Create individualized treatment plans
- Provide individual and couples therapy for a variety of clinical presentations, including substance abuse, PTSD, mood and anxiety disorders, and Axis II disorders
- Prepare case presentations for clinic case conferences and participate in weekly dyadic, group and peer supervision
- Provide coverage of after-hours emergency pager to ensure safety of at-risk clients

Supervisory Experience

September 2012 -
June 2013

Peer Supervisor

Pepperdine University Psychological and Educational Clinic, Los Angeles, CA
Supervisor: Aaron Aviera, Ph.D.

- Mentor first-year students who are beginning therapy training
- Assist with training students to develop therapeutic skills, discuss process issues, and introduce formal therapeutic intervention skills for students to implement in therapy
- Attend weekly case conferences to provide written and oral feedback for supervisees' case presentations
- Review supervisees' intake assessments, diagnostic formulations, case notes, and audio/digital data
- Meet weekly with licensed supervisor for supervisory training and didactics

Related Clinical Experience

September 2007 -
June 2008

Peer Counselor, University of California, Irvine, Counseling Center
Creating Options and Conquering Hurdles Program (COACH)
Supervisor: Marikyo Adams, LCSW

- Co-led support groups and workshops for students experiencing depression, anxiety, relationship concerns, and gender identity issues
- Assisted individual students with goal-setting and decision-making regarding academics and relationships

- September 2005 -
September 2007
- Research Assistant and Office Manager**
Barton J. Blinder, M.D., Ph.D., Licensed Psychiatrist, Clinical Professor
- Handled all administrative tasks such as, scheduling appointments, accounting, and handling confidential patient information
 - Conducted telephone screenings and patient referrals
 - Assisted in preparing several lectures and presentations for courses taught at UCI Medical Center, Department of Psychiatry and Human Behavior
 - Performed online and library research and for lectures and publications

Research Experience

- September 2010 -
Present
- Doctoral Dissertation**, Pepperdine University, Los Angeles, California
Chair: Shelly Harrell, Ph.D.
Committee members: Susan Himelstein, Ph.D. & Shereen Kianmahd, Psy.D.
- Validation of the Multidimensional Well-Being Assessment in the Iranian population
 - Original data collection for a quantitative study
- August 2010 -
July 2013
- Research Team Coordinator**
Pepperdine University, Graduate School of Education & Psychology
Advisor: Shelly Harrell, Ph.D.
- Assist in survey development involving multiple dimensions of psychological well-being across variety of cultural and age groups
 - Conduct literature reviews and pilot studies, write research grants, and assist with obtaining Institutional Review Board approval
 - Enter and analyze data utilizing SPSS
 - Assist with manuscript write-up
 - Assist in development of online interventions for research website geared towards assisting underserved populations
- September 2009 -
July 2013
- Multicultural Research and Training Lab Member**
Pepperdine University, Graduate School of Education & Psychology
Advisor: Joy Asamen, Ph.D.
- Attend monthly meetings to discuss multicultural research topics and receive feedback on clinical implications of dissertations topics pertaining to multicultural issues
 - Brainstorm ideas with committee members in planning innovative biennial conference
- September 2009 -
December 2009
- Research Assistant**
Pepperdine University, Graduate School of Education & Psychology
Advisor: Joy Asamen, Ph.D.
- Provided data management support to Director of Academic Assessment
 - Analyzed and interpreted data to enter error-free information into SPSS
 - Involved in survey development and advanced data analysis to evaluate enrollment decisions of students and motivating factors for attendance

September 2007 -
June 2008

Social Ecology Honors Program Member

University of California, Irvine, School of Social Ecology

Advisors: Salvatore Maddi, Ph.D. and Valerie Jenness, Ph.D.

- Wrote extensive literature review and conducted quantitative study to examine cultural impact, educational obstacles, and hardiness on psychological well-being of undergraduates
- Developed and administered over 200 surveys in the university setting
- Analyzed data using SPSS to determine impact of hardiness on well-being

September 2006 -
June 2008

Psychology & Social Behavior Excellence in Research Program Member

University of California, Irvine, School of Social Ecology

Advisors: Salvatore Maddi, Ph.D. and Valerie Jenness, Ph.D.

- Completed set of advanced courses in methodology and statistics to develop independent research study
- Performed mentored research and presented senior research thesis at scientific conference

September 2006 -
June 2008

Lead Researcher/Senior Scholar

University of California, Irvine, Department of Social Sciences

Advisor: Jeanett Castellanos, Ph.D.

- Conducted quantitative study to investigate Iranian female undergraduates coping procedures and psychological well-being
- Conducted quantitative study using a psychosociocultural theoretical framework to investigate Iranian female undergraduates body image perceptions
- Wrote an extensive literature review, produced survey work (i.e., developed a body image perceptions scale), and identified crucial variables (i.e., self-esteem and acculturation) influencing Iranian females' body image perceptions and well-being
- Completed manuscript write-up and utilized SPSS to analyze data

September 2006 -
June 2008

Undergraduate Research Opportunities Program Member

University of California, Irvine

Advisor: Jeanett Castellanos, Ph.D.

- Attained Institutional Review Board approval, performed literature reviews, collected and managed data set, and performed statistical analyses
- Attend weekly meetings with mentor to discuss research progress and receive feedback
- Presented final project to university faculty, associate dean, and undergraduate students

January 2006 -
June 2006

Research Assistant

University of California, Irvine, School of Social Ecology

Advisor: Ellen Greenberger, Ph.D. and Chuansheng Chen, Ph.D.

- Transcribed survey packets, coded materials, entered data in SPSS, and conducted telephone interviews for longitudinal study on adolescents in orphanages and shelters

September 2004 -
September 2006

Research Assistant/Junior Scholar

University of California, Irvine, Department of Social Sciences

Advisor: Jeanett Castellanos, Ph.D.

- Assisted with literature review, data collection, and data input on study examining Latinas and college adjustment
- Performed data input and counterbalancing for study investigating Vietnamese college students and well-being
- Assisted with study examining high school experience of Tijuana children border crossing to attain U.S. education by transcribing interviews, analyzing and interpreting qualitative data for focus groups and formulating themes on focus groups' findings

Publications & Presentations

Abou-Ziab, H., Peña, C., Park, E., **Moshfegh, N.**, & Harrell, S. (2013, August). Well-Being and the Immigrant Woman: Relational Strengths and Challenges from Three Parts of the World. Poster presented at the American Psychological Association Annual Convention, Honolulu, HI, USA.

Moshfegh, N. (2013, June). Cultural Considerations in the Well-Being of Iranian Americans. Oral presentation at the Third World Congress on Positive Psychology, International Positive Psychology Association, Los Angeles, CA, USA.

Harrell, S., **Moshfegh, N.**, Anderson, G., Orozco, M., Pena, C., Belle, N., Underwood, J., Park, E., Chimel, L., & Abou-Ziab, H. (2013, June). The Multidimensional Well-being Assessment (MWA): Measuring Relational, Collective, Transcendent, Psychological, and Physical Contexts of Wellness. Poster presented at the Third World Congress on Positive Psychology, International Positive Psychology Association, Los Angeles, CA, USA.

Moshfegh, N. (2012, October). Well-Being in Middle Eastern Populations. Oral presentation at the Multicultural Research and Training Lab Biennial Conference, Pepperdine University, Los Angeles, CA, USA.

Moshfegh, N. & Harrell, S. (2012, August). Well-Being and the Mental Health Needs of Iranian American Immigrants. Poster presented at the American Psychological Association Annual Convention, Orlando, FL, USA.

Harrell, S., **Moshfegh, N.**, Anderson, G., Orozco, M., Park, E., & Pena, C. (2012, March). Developing a Framework and Measure of Multiple Contexts of Well-Being: Personal, Relational, Collective, Transcendent, and Physical. Poster presented at the American Psychological Association Annual Conference of the Society for Humanistic Psychology, Pittsburgh, PA, USA.

Moshfegh, N. (2008, May). Hardiness and Psychological Well-Being in College Students. Oral presentation at the annual 2008 Undergraduate Research Opportunities Symposium. Irvine, CA, USA.

Moshfegh, N. (2008, May). Iranian Female Undergraduates Body Image Perceptions: A Psychosociocultural Perspective. Oral presentation at the annual 2008 UROP Symposium. Irvine, CA, USA.

Moshfegh, N. (2007, May). Iranian Female Undergraduates Body Image Perceptions: A Psychosociocultural Perspective. Poster presented at the annual 2007 UROP Symposium. Irvine, CA, USA.

Aragon, A. & **Moshfegh, N.** (2005, May). Experiences of Transborder Students in the United States. Poster presented at the annual 2005 UROP Symposium. Irvine, CA, USA. *Received Top 10 Poster Award*

Honors/Awards

September 2010 - Present	Pepperdine Colleagues Grant Scholarship
January 2009 - Present	National Honor Society in Psychology (Psi Chi), Pepperdine University Recognition of Outstanding Scholastic Achievement and Excellence
June 2008	Excellence in Research Award, UCI
June 2008	Social Ecology Honors Award, UCI
June 2008	Psychology and Social Behavior Excellence in Research Award, UCI
December 2007	Grant Recipient, Undergraduate Research Opportunities Program, UCI (Received for quantitative study on body image perceptions)
December 2007	Grant Recipient, Undergraduate Research Opportunities Program, UCI (Received for quantitative study on well-being in college students)
July 2007	Social Ecology Honors Program, UCI
May 2007	National Honor Society in Psychology (Psi Chi), UCI Recognition of Outstanding Scholastic Achievement and Excellence
September 2006	Psychology and Social Behavior Excellence in Research Program, UCI
September 2006	Grant Recipient, Undergraduate Research Opportunities Program, UCI (Received for quantitative study on body image perceptions)
September 2006 - September 2007	Dean's Honor List, UCI (seven consecutive quarters) Recognition for excellence in academics

Professional Affiliations

January 2009-Present	National Honor Society in Psychology (Psi Chi), Member
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Language Proficiency

Bilingual in Farsi/English

ABSTRACT

Although nations with a dominant worldview of individualism are a minority in the world as a whole, most psychological models are generated based on research conducted in these countries. Existing models and measures of well-being tend to have an individualistic, Western cultural bias, making it difficult to assess the well-being of those whose dominant worldview is more consistent with collectivism. Due to the absence of an existing cross-culturally relevant measure of well-being, the Multidimensional Well-Being Assessment (MWA) was developed. As attention to Middle Eastern populations has not typically received much consideration in psychological literature, this study aimed to inform researchers and clinicians of critical issues relevant to the well-being of those with ancestry and identity in Iran in addition to examining the validity of the MWA in an Iranian sample. This study used a non-random sampling method for data collection and utilized a cross-sectional correlational design to examine both the validity of the MWA and the relationship of dimensions of well-being to several demographic variables. A total of 62 participants were included in this study. The MWA showed good to excellent reliability on most MWA contexts and dimensions, in addition to showing significant positive correlations with two additional measures of well-being and significant negative correlations with a measure of distress and dysfunction. Significant correlations between several demographic variables (including age, length of time in the United States, and relationship status) and several dimensions on the MWA were also found. This study has implications for future research within the fields of culture and well-being with particular attention to unique findings within the Iranian population.

Chapter I. Introduction

When it comes to being happy or living the “good life,” are there only some groups that have it right? How one’s culture and context influence and shape both the perception and reality of well-being is a topic of growing interest. However, as research on the concept of well-being has vastly increased over the years, there still remains a large gap in the literature on the cultural informants of well-being and its correlates. Although numerous studies have attempted to capture the determinants of well-being and mental health across cultures, some ethnic minority populations have been significantly overlooked. Moreover, researchers have yet to come to a consensus on what determines well-being across cultures, with some suggesting that the individualism-collectivism continuum may be important in determining the perception of well-being and others, ignoring this worldview dimension, look to factors such as genetics, personality, age, socioeconomic status, and various other contributions (Diener & Suh, 2000).

Efforts to examine well-being cross-culturally have predominantly been accomplished by looking at differences between nations, with less literature available on the differences between diverse cultures within the same nation. As immigrants and their U.S.-born descendants are expected to provide most of the U.S. population gains in the decades ahead (Passel & Cohn, 2008), it is imperative that efforts to examine the well-being of diverse populations be made in order to inform researchers and clinicians on how best to aid these individuals towards achieving optimal functioning and decreasing the presence of mental illness in these communities.

Middle Easterners are one of the fastest growing immigrant groups in the United States (Camarota, 2002). While the size of the overall immigrant population (legal and illegal) has tripled since 1970, the number of immigrants from the Middle East has grown more than seven-fold, from fewer than 200,000 in 1970 to nearly 1.5 million in 2000 (Camarota, 2002). Additionally, the total Middle Eastern immigrant population was estimated to be at about 2.5

million in 2010, not including the estimated 950,000 U.S. born children who have at least one parent born in the Middle East (Camarota, 2002). Individuals of Middle Eastern descent are one of the many ethnic minority populations that have not been given enough attention within mental health literature in general, and well-being literature in particular. Contributing to this problem is a shortage of valid culturally congruent measures of well-being and the lack of recognition of Middle Easterners as a racial-ethnic group distinct from “White” in the literature.

Purpose and Importance of Study

Although nations with a dominant worldview of individualism (e.g., the United States, Australia, Western Europe) are a minority in the world as a whole (Triandis, 1995), most psychological models are generated based on research conducted in these countries. Existing models and measures of well-being lack an integration of the significance of community, culture, and spirit, and tend to have an individualistic, Western cultural bias, making it difficult to assess the well-being of those whose dominant worldview is more consistent with collectivism. Due to the absence of an existing cross-culturally relevant measure of well-being, Harrell et al. (2012) developed the Multidimensional Well-Being Assessment (MWA). In Harrell’s multidimensional model, well-being is defined as “positive appraisal of valued contexts of lived experience including emotional experience, functioning in the world, experience of the physical body, and experience in relationship to others, culture, community, spirituality, and self” (para. 6). As this framework incorporates the idea that different contexts of well-being may be differentially valued based on culture, socialization, and individual values, it is hypothesized that patterns of validity may vary among different cultural groups.

As attention to Middle Eastern populations has not typically received much consideration in psychological literature, this study aims to inform researchers and clinicians of critical issues

relevant to the well-being of a specific subset of Middle Easterners who have not received much attention in the literature, specifically those with ancestry and identity in Iran. In order to do so, the proposed study will review literature on (a) current demographic data of the Iranian population in the United States, (b) the historical, sociopolitical, and cultural context of Iran and its relationship to the United States, (c) available conceptual and empirical literature pertaining to the mental health of Iranians, and (d) a discussion of the implications for understanding and facilitating well-being in this population.

The study will also discuss the limitations of current conceptualizations of well-being, with particular regard to culture and efforts of the MWA to address these limitations. In order to confirm the hypothesis that the MWA will be a culturally valid assessment measure, the study will additionally examine the validity of the MWA in an Iranian population living in the United States. This study has implications for future research within the fields of culture and well-being with particular attention to unique findings within the Iranian population.

Research Questions

As the study is descriptive in nature, hypotheses will not be generated. The data collected will inform the psychometric properties of the MWA in the Iranian population as well as examine the following research questions:

- *Question 1:* What is the reliability and validity of the MWA in a sample of persons of Iranian descent living in the United States?
- *Question 2:* How are different contexts of well-being (i.e., psychological, relational, collective, transcendent, and physical) rated in a sample of Iranians living in the United States?
- *Question 3:* How do gender, age, place of birth, length of time living in the United States, religious affiliation (i.e., Muslim, Jewish, Christian, or other), relationship status, child or elderly caregiver status, level of education, work or student status, socioeconomic status, and illness and levels of perceived stress contribute to levels of well-being in a sample of persons of Iranian descent?

Chapter II. Review of the Literature

Dimensions of Culture

Matsumoto (2000) defines culture as:

A dynamic system of rules—explicit and implicit—established by groups in order to ensure their survival, involving attitudes, values, beliefs, norms, and behaviors, shared by a group but harbored differently by each specific unit within the group, communicated across generations, relatively stable but with the potential to change across time. (p. 39)

Therefore, culture exists on multiple levels, across individuals within groups and across groups within larger groups.

Culture exists on three levels: the cultural level, the demographic level, and the individual level (Triandis, 1994). Whereas the cultural level can be measured by the nation of origin or other grouping by geographical proximity, the demographic level is measured by factors such as, ethnicity, race, gender, or other demographic characteristics (Triandis, 1994). On the individual level, however, culture is viewed as a pattern of construct variation unique to the individual, which cannot be meaningfully interpreted by reference to demographic or cultural membership (Triandis, 1994).

Culture can also be viewed through the lens of various syndromes or patterns. Accordingly, culture can be judged based on the extent to which societal norms are complex (i.e., having many choices and roles) or simplistic (i.e., having few choices and roles; Diener & Suh, 2000). Culture can also be understood on the extent to which sanctions are tight (i.e., strict opposition) versus loose (i.e., tolerance) when members deviate from the norms of society (Diener & Suh, 2000). Furthermore, cultures can also be classified as individualistic or collectivistic based on certain patterns (Triandis, 1995).

Individualism is found in societies in which the self is regarded as autonomous, personal goals have priority over in-group goals, attitudes are the most important determinants of behavior, and social exchanges characterize interpersonal relationships (Triandis, 1995). Therefore, in individualistic societies emphasis is placed on the centrality of the individual. Individualism is maximal in complex-loose societies (such as the U.S.). Collectivism, on the other hand, is found in societies where the self is regarded as an aspect of groups, interdependent with members of those groups (Triandis, 1995). In collectivistic cultures, in-group norms have priority over personal needs such that cultural norms are as important as (or more important than) individual attitudes in determining behavior, and relationships are viewed as communal (Triandis, 1995). Emphasis is placed on the centrality of the group. Collectivism is maximal in simple, tight societies (Triandis, 1995), such as East Asian or Middle Eastern cultures, and is the dominant worldview for Iranians, as detailed below.

Iranian Culture

Iran is a pluralistic society. Persians are the largest ethnic group in Iran, though many are of mixed ancestry. Iran's population includes Kurds, Balochi, Bakhtyari, Lurs, and other smaller minorities, such as Armenians, Assyrians, Jews, and Brahuis (or Brohi). Most Iranians are Muslims; 89% belong to the Shi'a branch of Islam, the official state religion, while about 9% belong to the Sunni branch. Non-Muslim minorities include Christians, Zoroastrians, Jews, and Baha'is (U.S. Department of State, 2012).

Nuclear families are rarely seen within traditional Iranian culture. The family unit is often extended, with grandparents, uncles, aunts, and cousins seen as part of the primary family. Intra-familial marriage is common within Persian tradition (although less of this has been practiced within the United States; U.S. Department of State, 2012).

According to traditional Iranian culture, children are expected to be obedient towards authority figures and displays of negative emotion are often discouraged (Shamloo, 2010). In addition, men are typically viewed as the head of the household, maintaining an authoritarian stance. There are often contradictions within the relationship between fathers and sons, as children are often expected to be obedient towards their parents, yet young boys are also taught to be independent, with the goal of one day taking on the role of the father-figure within their own home. The relationship between mothers and sons is also noteworthy, as sons often have special relationships with their mothers, which can cause conflicts between wives and mother-in-laws (Shamloo, 2010). Men are often encouraged to incorporate their wife into their family of origin and often need to balance the opinions of their mother between the opinions of their spouse.

Iranian Immigration to the United States

The first wave of Iranian immigration occurred between 1950 to about 1970 (Jalali, 1996). During this period, a main purpose for immigration was to pursue or continue professional or academic careers. Iranians who immigrated during this period were most likely already exposed to Western ideals, as they maintained higher levels of education in pre-revolutionary Iran (Jalali, 1996).

The second wave of Iranian immigration occurred between the years of 1970 to 1978 (Jalali, 1996). During this period, Iranians mostly immigrated to pursue economic and professional gains and to obtain better educational and occupational opportunities for their children (Jalali, 1996). Most Iranians who immigrated during this period had higher economic standing and most were able to maintain their success in the U.S. (Jalali, 1996).

The third wave of immigration occurred between the years of 1978 to 1984 due to the Islamic Revolution of 1979 (Jalali, 1996). During this period, most Iranians immigrated due to economic, political, and religious constraints (Jalali, 1996).

The fourth and final wave of immigration occurred in the mid-1980's during the Iran-Iraq war (Jalali, 1996). Most Iranians immigrated during this period to escape the perils of the war. Because of the disruption in family unity, and the political, ideological, and physical separation of their country of origin, third and fourth wave immigrants were more susceptible to developing psychological symptoms (Jalali, 1996).

The 1979 Islamic Revolution and the 1980-88 Iran-Iraq war transformed Iran's class structure politically, socially, and economically. During this period, Shi'a clerics took a more dominant position in politics and nearly all aspects of Iranian life, both urban and rural. After the fall of the Pahlavi dynasty in 1979, much of the urban upper class of prominent merchants, industrialists, and professionals, favored by the former monarch, lost standing and influence to the senior clergy and their supporters. Bazaar merchants, who were allied with the clergy against the Shah, also gained significant political and economic power after the revolution (Mazarei, 1996).

Iranians in the United States. Iranian Americans are one of the most educated and entrepreneurial ethnic groups in the United States (Bozorgmehr & Douglas, 2011). Among Iranian-American males, approximately two-thirds of both first and second generation immigrants hold a Bachelor's degree or higher (Bozorgmehr & Douglas, 2011). Foreign-born Iranian males have a higher level of post-graduate education; however, this is most likely a byproduct of the difference in age between the first and second generations (Bozorgmehr & Douglas, 2011). For Iranian females, almost half (49%) of those classified as first-generation

hold a bachelor's degree or higher, while 70% of those classified as second-generation have earned college and higher degrees (Bozorgmehr & Douglas, 2011). The educational attainment of second-generation females has surpassed that of their male counterparts and has equaled the educational attainment of first-generation males despite the age gap, pointing to a change in women's educational aspirations in the second-generation. While differences in educational attainment between first-generation males and females are significant, it is no longer the case in the second generation.

First-generation females (62%) have a much lower rate of Labor Force Participation (LFP) than their male counterparts (89%), despite their relatively high educational levels (Bozorgmehr & Douglas, 2011). Although often attributed to patriarchy, the low LFP rate of the first-generation Iranian women can be conceptualized as a strategy to ensure that children get proper parental attention during their schooling, especially since self-employment forces many Iranian businessmen to spend long hours at work (Bozorgmehr & Douglas, 2011). When Iranian husbands' incomes are sufficiently high to support their families, wives need not work full-time, despite their generally high levels of education. A combination of high family income, highly-educated parents, and familial support gives Iranian parents an unusual mix of resources to provide for and supervise the education of their children (Bozorgmehr & Douglas, 2011).

Second-generation Iranian women almost closed the gap in LFP with men (76% vs. 88%; Bozorgmehr & Douglas, 2011). However, because second-generation females are still young and most likely unmarried, it is not yet clear whether they will continue their labor force participation or choose to stay home to supervise their children after marriage. Reflecting their high educational levels, many Iranians hold professional specialty occupations in the United States (Bozorgmehr & Douglas, 2011). The top three categories, which the vast majority of

Iranians occupy, include “Managerial and Professional” (p. 20), which includes professional occupations in business and finance, “Technical and Administrative” (p. 20), which includes doctors, dentists, engineers, lawyers, and other high-skill professions, and “Sales” (p. 20), which includes retail and industrial sales, and thus many of the self-employed (Bozorgmehr & Douglas, 2011).

Second-generation Iranians are becoming more concentrated in professional occupations in the high-skill sectors of the labor force (Bozorgmehr & Douglas, 2011). Employment in both managerial and technical occupations has increased across genders in the second generation (Bozorgmehr & Douglas, 2011). Second-generation males report higher percentages of employment in both “managerial” (25%) and “technical” (40%) occupations than their first-generation counterparts (Bozorgmehr & Douglas, 2011, p. 21). Over one-third (39%) of first-generation females report employment in “Technical and Administrative” occupations, and over half (56%) of second-generation females report this type of employment (Bozorgmehr & Douglas, 2011, p. 21).

In 2000, Iranians ranked third, after Greeks and Koreans, in self-employment rate among the twenty largest immigrant groups in the United States. The rate for Iranians was 22%, compared to 26% for Greeks and 23% for Koreans (Fairlie, 2008). Unlike other immigrant groups who turn to self-employment because of disadvantages in the labor market (e.g., language barriers), self-employment for Iranians, especially among former middleman minorities, defined as minority entrepreneurs, such as Armenians or Jews, who mediate between the dominant and subordinate groups (Blalock, 1967), spurs entrepreneurship.

Using data from the “Survey of Iranians in Los Angeles,” Der-Martirosian (2008) identified determinants of male Iranian immigrant entrepreneurship to be: previous experience of

self-employment in Iran, belonging to a religious minority group in Iran (e.g., Jewish), and utilizing economic networks in Los Angeles (i.e., for employee or customer relations and transportation to work). Availability of capital, and the presence of highly skilled self-employed professionals, such as doctors and dentists, can further contribute to the high self-employment rate of Iranians.

With a self-employment rate of 25%, according to the American Community Survey (ACS; U.S. Census Bureau, 2007) 2005-2007 data, Iranians continue to be one of the most entrepreneurial groups in the United States. As expected, the self-employment rate is higher among the first generation (31% for males, 20% for females) than among the second (23% for males, 12% for females). However, starting a business takes time, especially the professional incorporated type which is prevalent among the second generation (e.g., doctors, dentists, and lawyers). Hence, their incidence of self-employment may be higher in the future than the data suggest at this time.

Immigration and acculturation. The acculturation process for immigrants has important implications for mental health. Recent research conceptualizes acculturation as a bilinear (i.e., cultural socialization to mainstream and ethnic cultures proceeding relatively independently from each other) and multidimensional (i.e., across multiple areas such as behaviors, cultural identity, knowledge, values) cultural socialization process that occurs in interaction with social contexts (e.g., home, school, work, and community; Kim & Abreu, 2001; Miller, 2007; Schwartz, Unger, Zamboanga, & Szapocznik, 2010; Yoon, Langrehr, & Ong, 2011).

Some hypothesize that fully adapting to the host culture is beneficial for mental health (Griffith, 1983), while others argue that maintaining native belief systems (i.e., enculturation)

contribute to better mental health outcomes (Ramirez, 1969). Still other researchers have argued that maintaining a bicultural identity, in which the immigrant both adapts to the host culture and maintains native belief systems, is the most beneficial for mental health (Buriel, Vasquez, Rivera, & Saenz, 1980; Fernandez-Barillas & Morrison, 1984; Szapocznik, Kurtinez, & Fernandez, 1980). A more recent meta-analysis examining acculturation, enculturation, acculturation strategies, and mental health (Yoon et al., 2013), found that acculturation was favorably associated (negatively) with negative mental health (i.e., depression, anxiety, psychological distress, and negative affect) and (positively) with positive mental health (i.e., self-esteem, satisfaction with life, and positive affect), whereas enculturation was favorably related only to positive mental health (positively). Enculturation was also positively related to anxiety (Yoon et al., 2013).

Ghaffarian (1998) examined 238 Iranian immigrants to the United States, who immigrated after the 1979 Iranian Revolution, obtaining data through quantitative surveys measuring degree of acculturation, anxiety, depression, and psychosocial dysfunction. Relevant demographic information, such as age, gender, level of education, and number of years in the United States, was also gathered. Consistent with the hypothesis, Ghaffarian (1998) found that maintaining a bicultural identity produced the least amount of mental disturbances and the highest amount of mental health. Ghaffarian (1998) found that while adapting to the host culture is important, maintaining some Iranian cultural values is also important. Interestingly, the study also found that men had an easier time adapting to U.S. culture than women. This finding may have occurred because Iranian men have less to adapt to than Iranian women, as Iranian culture is traditional in the manner they treat women.

Hojat et al. (2000) compared 160 Iranian male and female immigrants between the ages of 20 and 50 years living in the United States, and found differences in Iranian immigrants' attitudes toward marriage and family. Hojat et al. (2000) distributed a 10-item attitudes scale, measuring the degree of traditional Iranian attitudes towards premarital sex, marriage, and the family, and found that Iranian men scored significantly higher than Iranian women on the traditional attitudes scale, after accounting for age. This discrepancy may have occurred due to the heavy restrictions and social pressures placed on women in Iran, which may contribute to a greater readiness to adopt more mainstream American values and behaviors. The authors also proposed that the Iranian woman's higher rate of acculturation (as identified by their more liberal attitudes towards sex, marriage, and family) may be contributing to higher divorce rates among Iranians living in the United States versus those living in Iran (Hojat et al., 2000).

Jodeyr (2003) hypothesized that Iranian immigrants may utilize splitting as a defense mechanism to deal with conflicts over the vast differences between Iranian and American culture. Jodeyr (2003) postulates that Iranian immigrants tend to associate the host culture as all good and ideal upon first arriving to the country, while their home culture is associated with bad and negative connotations. The splitting occurs as a result of the anxiety the immigrant experiences in adapting to the host culture. Because the immigrant often experiences discrimination in the host culture and confusion with respect to the stark differences between cultures, assimilation may result as an attempt to resolve the internal conflicts experienced. It has been suggested that the immigrant's use of their native language is important in their identity development (Graafsma, Bosma, Grotevant, & de Levita, 1994). The second generation immigrant often loses touch with his or her own language in an attempt to assimilate. However,

language is often what maintains a positive connection to the immigrant's home culture and may facilitate well-being in the context of acculturative stress (Jodeyr, 2003).

Jodeyr (2003) additionally hypothesized that an unconscious guilt may be passed down to the children of Iranian immigrants, as parents often had to abandon their own hopes, dreams, and aspirations for the future. In some situations, the immigrant's level of education is not recognized in the host nation, forcing them to take on a lower status, working class position (Jodeyr, 2003). Therefore, children may be pressured to succeed in school so as to overcome the burden of the migration their parents had to endure (Jodeyr, 2003). Failures may be highly scrutinized, which may lead to feelings of frustration, guilt, and humiliation on the part of the child (Jodeyr, 2003). Family dynamics such as those described here are important to consider in understanding the well-being of Iranians in the United States.

Ethnic identity in Iranian immigrants. Mahdi (1998) discussed the issue of ethnic identity in second generation Iranian immigrants living in the United States. Second generation status was defined by the author as, "either youths born in the United States with at least one foreign-born parent or youths who were born abroad but had lived in the United States for at least five years" (Mahdi, 1998, p. 5). Mahdi (1998) additionally defined identity as a concept of how individuals define themselves in terms of their affiliation with and commitment to a social group, sociocultural system, politico-national entity, and ethnic community.

Mahdi (1998) administered a questionnaire with 50 closed-ended questions designed to assess Persian language proficiency of second-generation Iranians in the United States, identification with Iranian culture, ethnic attachment, and practice of religious duties. The sample included 183 male and 218 female respondents with a mean age of 17.6 and median age of 17. Approximately half of the sample (51.3%) was born in Iran, 45% in the United States, and

three percent in other countries. The respondents were asked to identify with one of the following four categories: "Iranian," "Iranian-American," "American," and "other." About half of the respondents (51.8%) identified as "Iranian-American," 32.4% as "Iranian," and only 10.7% as American. The remaining 5.1% chose "other," with only three specifications: "Iranian-British," "Iranian-Arab," and "Kurdish."

Mahdi (1998) found a strong relationship between ethnic identification and the concentration of a co-ethnic population where the individual resides. In California, where one-third of Iranians reside, and where Iranians interact more often, the percentage of those identifying themselves as "Iranian" was 21% higher (Mahdi, 1998). Mahdi (1998) also found, the greater the number of years lived in the United States, the less likely the individual was to identify himself or herself as only "Iranian."

Additionally, Mahdi (1998) found that the more respondents were engaged in certain activities (e.g., having many Iranian friends, speaking Farsi, and attending ceremonies and cultural activities), the more likely they were to identify themselves as either "Iranian" or "Iranian-American." Furthermore, the more parents had engaged their children in cultural socialization activities associated with Iranian culture and community, the more successful they were in creating a sense of appreciation for their culture among their children. Mahdi (1998) also found that the respondents characterized being Iranian (vs. "American") as being emotional, suspicious, polite, hospitable, and family oriented.

Mostofi (2003) describes Iranian-American identity as a combination of the American notions of freedom and liberty and Iranian cultural traditions and concepts of the family. Mostofi (2003) explored the identity of Iranian immigrants by distributing a questionnaire to 25 Iranian immigrants living in the United States. According to the questionnaire, the main

components of Iranian identity were identified as family, education, hospitality, and artistic traditions. Symbols of Iranian culture such as, food, pre-Islamic holidays and traditions, history, domestic values and kinship ties, and etiquette, serve as reminders of an Iranian individual's origin (Mostofi, 2003). Mostofi (2003) argues that as a group, Iranian immigrants have assimilated into their perception of American life, defined as civic nationalism and economic participation. At the same time, they have also maintained an Iranian identity formed by an awareness of Iranian traditions. To Mostofi, Iranian awareness or consciousness consists of maintaining the Persian language, closeness of family, traditional nonreligious holidays, and a pre-Islamic history. Like many other immigrant groups, some Iranians in the United States have forged an identity incorporating elements from both their ethnic traditions and the new U.S. mainstream civic society, which they keep separated into the private and the public spheres (Mostofi, 2003). Mostofi (2003) suggests that Iranians attempt to “blend” (p. 691) into mainstream America by using their relative “whiteness” (p. 691) to benefit both from American liberal society and hide from the prejudices that may follow them due to the political hostilities between the United States and Iran.

Mostofi (2003) additionally argues that through the process of assimilation, Iranians have utilized their bodies to uphold an image of a “white model minority” (p. 694). Mostofi states that:

The importance of blending into the perceived norms of mainstream society for the facilitation of a more comfortable life without the harassment felt during the hostage crisis manifests through plastic surgery, fake contact lenses, extraordinary diets to the point of anorexia, dyed hair, plucked eyebrows, and the removal of body hair. There

exists no tangible statistics for the number of Iranians utilizing such measures to ‘whiten’ their bodies. (p. 694)

Mostofi’s (2003) statement highlights the importance of examining methods of acculturation utilized by Iranian immigrants to assimilate into mainstream American society and its subsequent impacts on mental health.

Iranian Mental Health Conceptualizations

Martin (2009) explored whether the manner mental health is conceptualized by older Iranian immigrants influenced their mental health-related practices. Martin (2009) interviewed seven men and eight women ranging in age from 53 to 87, who all left Iran after the age of 50 and had been in the United States for an average of 13.5 years. All of the participants had a minimum of a high school degree, including five participants with a college degree. Many participants described their English as minimal and self-taught. Because older Iranian immigrants are more resistant to acculturation, they are at increased risk for developing mental health problems (Martin, 2009).

Participants used two words in Farsi to conceptualize mental health (*hal* and *salamati*), which refers to the overall condition of one’s mind, body, and spirit (Martin, 2009). In other words, older Iranian immigrants did not distinguish between mental and physical health. Iranians presented a more holistic concept of health in Martin’s (2009) study, describing health in the categories of physical and spiritual (*ruhi*). To Iranians, physical refers to the body, and spiritual refers to everything that is non-flesh, including the mind, emotions, and spirit or soul (Martin, 2009). Therefore mental health was perceived as synonymous with spiritual or *ruhi* health for Iranians interviewed. The Iranians in Martin’s (2009) study described spiritual health as experienced more in the chest, stomach, and heart region, rather than in the head or brain

region as often described in the Western description of "mental health." The vocabulary of colloquial Farsi lacks the type of specialized terminology available in ordinary English to provide distinct descriptions of different types of emotions and illnesses, making it difficult for Iranian immigrants to describe their mental health concerns to mental health professionals.

The findings from Martin's (2009) study suggest that differences in mental health conceptualization are significant in explaining the mental health-related behaviors of older Iranian immigrants. This study showed that older Iranian immigrants embrace a holistic approach to health care that views mind, body, and spirit as inseparable. The study also found that older Iranian immigrants are generally reluctant to seek mental health services. This resistance was largely attributed to the cultural differences in mental health conceptualization (language, definitions, and terminology) and lack of trust in the effectiveness of psychotropic medications.

Jafari, Baharlou, and Mathias (2010) found an increasing rate of divorces and family splits, problems in personal relations, aggressiveness, anxiety, suicide attempts, and determination to return to their home country among different groups of Iranian immigrants to Canada. They noted that while some have attributed poor mental health status among Iranian immigrants to the changes in the status and position of Iranian men, others believe the changes in the power structure of the family may intensify pre-immigration conflicts and encourage divorces. Jafari et al. (2010) interviewed 44 Iranian immigrants in focus groups, classified into three age groups: young adults, adults, and elderly. Jafari et al. also conducted 10 in-depth interviews with staff members and community workers of Iranian origin. Their results suggested that most of the participants had difficulty defining the term mental health, as the majority of

individuals misunderstood the definition of mental health as a mental disorder, mainly because mental health was misinterpreted as psychiatric illnesses.

The participants in the study perceived mental health in relation to concepts such as good relationships, proper manners, effectively communicating with people, and being honest and trustworthy. Overall, the participants referred to both emotional and psychosocial aspects of mental health simultaneously. They considered mental health as the coordination between the person's mind, emotion, and behavior and believed people cannot be considered mentally healthy unless their actions comply with the norms and rules. It is suggested that in Iranian culture it is believed that mental health and general health are interrelated and both affect daily life, as well as interactions with colleagues, friends, family, and society (Jafari et al., 2010).

Jafari et al.'s (2010) study also examined factors affecting the mental health of Iranian immigrants in Canada, which included: English fluency, communication problems, cultural barriers, employment, and the effects of immigration on interfamily relationships. Jafari et al. found that intra-familial problems were obvious in the young adults' focus groups. Most of the participants in this age group believed their parents were reluctant to understand their priorities. Male adult participants, on the other hand, believed immigration had changed the hierarchy of power in their families in a way that their children were no longer obedient. These changing dynamics suggest challenging conflicts between children and parents, which may increase risk for experiencing mental health problems (Jafari et al., 2010).

Shahmirzadi (1983) suggests that it may be difficult to establish rapport with Iranian clients due to their distrust of the counselor and therapeutic practices in general. However, Shahmirzadi also states that Iranians often view the counselor as an authority figure and hold them in higher regard, showing them respect by standing up when they enter or leave the room.

At times, older family members may also accompany the client to the counseling session (Shahmirzadi, 1983). Formality is also very important within Iranian culture and Iranian clients may be expected to be addressed by their last names, at least until rapport is established (Shahmirzadi, 1983). Because most Iranian clients will most likely have no prior experience in therapy or counseling, structuring the session and role teaching has been suggested to be important when engaging in therapy (Shahmirzadi, 1983). Therapists must also not be discouraged when Iranian clients do not express negative emotion, as they are often discouraged from expressing emotion around authority figures (Shahmirzadi, 1983). Therefore, clinicians must encourage their clients to feel comfortable in expressing negative emotions.

With respect to gender roles, direct eye contact between individuals of the opposite sex is seen as inappropriate within traditional Iranian culture (Shahmirzadi, 1983). Moreover, sitting and standing distance is typically closer for members of the same-sex as opposed to members of the opposite sex (Shahmirzadi, 1983). Self-disclosure may also be difficult for individuals within Iranian culture, especially for men and married women (Shahmirzadi, 1983). Many Iranian immigrants also experience a loss of status and prestige, which is highly regarded within the culture and may need to be a focus of treatment. Iranian men also closely identify with the concept of “machismo,” as courage, honor, and manhood are highly regarded and upheld (Shahmirzadi, 1983). The role and centrality of the family unit is also imperative in understanding Iranian clients (Shahmirzadi, 1983).

Although there is not a lot, existing research with the Iranian American community suggests several factors as pertinent to the well-being of this population. The importance of family was noted to be a central factor in both the identity and mental health outcomes of Iranian Americans (Hojat et al., 2000; Jafari et al., 2010; Jodeyr, 2003; Mostofi, 2003; Shahmirzadi,

1983; Shamloo, 2010), in addition to themes of hospitality and politeness (Jafari et al., 2010; Mahdi, 1998; Mostofi, 2003). Because maintaining a bicultural identity was identified as promoting higher rates of mental health in Iranian immigrants in the U.S. (Ghaffarian, 1998), factors such as age, time period of immigration, years living in the U.S., gender, language abilities (both English and Farsi), geographic residence within the U.S., and participation in Iranian cultural activities are important to consider in examining the well-being of Iranian immigrants. As mental health is thought to be interrelated with physical and spiritual health among Iranian immigrants (Jafari et al., 2010; Martin, 2009), religious and spiritual beliefs will additionally be relevant factors to consider.

Current Conceptualizations of the Construct of Well-Being

Research on the concept of well-being, which is defined as an optimal level of psychological experience and functioning, has vastly increased over the years (Deci & Ryan, 2006). There are a variety of theoretical frameworks within which well-being is examined, ranging from biological theories concerned with the genetic predispositions for happiness to relative standards theories, which examine how comparing oneself to others influences perceived subjective well-being (Diener & Ryan, 2011). Historically, well-being research has fallen into either the hedonistic or the eudaimonic traditions. Whereas the former focuses on happiness and the presence of positive affective states, the latter takes on a humanistic viewpoint, emphasizing life satisfaction and self-actualization. Although the majority of well-being research has been separated into the two camps, recent research suggests an overlap and correlation between hedonic and eudaimonic well-being (Keyes, Shmotkin, & Ryff, 2002).

The concept of subjective well-being (SWB; Diener, 1984), closely associated with the term “happiness,” has traditionally followed a more hedonistic approach, as it refers to the extent

to which one subjectively experiences high levels of positive affect, low levels of negative affect, and high levels of life satisfaction. However, the concept of psychological well-being (Ryff, 1989) involves a more eudaimonic approach to well-being, as it measures the characteristics of self-acceptance, personal growth, relatedness, autonomy, relationships, environmental mastery, and purpose in life. Although these two perspectives towards well-being have considerable overlap, they are also empirically distinct, contributing to an overall picture of mental health. Social well-being has also been examined as an important concept in the general understanding of mental health. Keyes (1998) defines social well-being as the appraisal of one's circumstance and functioning in society, which includes the dimensions of coherence, integration, actualization, contribution, and acceptance.

Other researchers have additionally focused on an alternate theoretical approach in understanding the concept of wellness or well-being. For example, based on the work of Sweeney and Witmer (1991) and the theoretical underpinnings of Adlerian psychotherapy, Myers and Sweeney (2005) developed the Indivisible Self (IS-Wel) model, as an evidence-based model of wellness. In the IS-Wel model, the self is at the core of wellness, which includes five components: the creative self, the coping self, the social self, the essential self, and the physical self. The IS-Wel model also includes four contexts as integral to individual wellness: local (safety), institutional (policies and laws), global (world events), and chronometrical (lifespan). The components of the IS-Wel model are measured using the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005; Myers, Sweeney, & Witmer, 2000), with versions for adults, middle school students, and elementary school students, as well as several cultural adaptations in languages other than English.

Although the IS-Wel model of wellness attempts to incorporate several aspects of well-being, there have been no theories tested to date which incorporate the multifaceted aspects of well-being. Moreover, most current theories on well-being are Euro-centric and do not take culture into consideration, which may skew well-being literature, particularly for ethnic minority populations (Christopher, 1999). The specific approaches within which well-being has been examined will be explored in further detail next.

Well-Being Theories

Hedonic well-being. The hedonic approach to well-being reflects the view that well-being consists of happiness or pleasure (Kahneman, Diener, & Schwarz, 1999). Researchers who have adopted this view point tend to focus on the preferences and pleasures of the mind and body (Kubovy, 1999). Therefore, hedonic well-being consists of subjective happiness and the experience of pleasure and displeasure. Happiness is viewed not only as related to physical pleasure, but also to the attainment of goals and values (Diener et al., 1998). Because psychologists who follow hedonic theory equate hedonism with happiness, the hedonic well-being literature focuses on identifying the ways in which people go about maximizing human happiness. Some have argued, however, that hedonic well-being is too narrow in its view, as it does not examine other aspects of well-being (Deci & Ryan, 2001). Most research within the field of hedonic psychology has evaluated the pleasure and pain continuum utilizing the assessment of Subjective Well-Being (SWB; Diener & Lucas, 1999). Diener and Lucas (1999) argue that SWB consists of the components of life satisfaction, the presence of positive mood, and the absence of negative mood. Diener posits that an individual is thought to be high in SWB to the extent to which the individual strongly endorses these three components.

Eudaimonic well-being. The eudaimonic approach to well-being argues that well-being consists of more than just happiness. Waterman (1993) argues that well-being lies in the actualization of human potentials and the fulfillment or realization of one's daimon or true nature. The eudaimonic viewpoint can be traced back to the writings of Aristotle and draws upon concepts within the field of humanistic psychology. The most common measurement of eudaimonic well-being is psychological well-being (Ryff, 1989). Ryff's theory of psychological well-being is also informed by the writings of Aristotle, and the work of such psychodynamically and humanistically oriented psychologists as Jung, Maslow, Allport, and Rogers. Ryff's approach to well-being measures six characteristics consisting of self-acceptance, personal growth, relatedness, autonomy, relationships, environmental mastery, and purpose in life.

Social well-being. Keyes (1998) defines social well-being as, "the appraisal of one's circumstance and functioning in society" (p. 122). Keyes (1998) argues that there are several social challenges that constitute dimensions of social well-being. The first challenge, social integration, consists of the extent to which one feels a commonality with others. Social integration emphasizes collective membership and the degree to which one feels a sense of belonging in their community. Another challenge, social acceptance, describes the ability for an individual to trust and be kind to others, stemming from self-acceptance. Moreover, social contribution involves the evaluation of one's social value and ability to contribute to society. Social actualization involves the belief in the evolution of society and the ability to be hopeful that society is able to reach its potential. Social coherence involves an individual's ability to make sense of, organize, and understand their social world. Individuals high in this aspect are able to make sense of and ultimately have a better ability to handle the inevitable tragedies and disappointments of life.

Measurements of Well-Being

Psychological Well-Being Scale. Ryff (1989) developed a scale to assess her theoretical conception of psychological well-being, borrowing from Maslow's (1968) view on self-actualization, Rogers' (1961) view on the fully functioning person, Jung's (1933) concept of individuation, Allport's (1961) view on maturity, Erikson's (1980) psychosocial stages, and Buhler (1935), Neugarten (1968), and Jahoda's (1958) life span developmental perspectives. Ryff (1989) hypothesized that psychological well-being is determined by six dimensions, specifically, autonomy, environmental mastery, positive relations with others, personal growth, self-acceptance, and purpose in life. Ryff's original scale consisted of a total of 120 items (with 20 items per dimension) and was validated on 321 Caucasian men and women divided among young, middle-aged, and older adults that were, overall, relatively healthy, well-educated, and financially comfortable. Ryff later developed a shorter version of the scale, which consisted of a total of 84 items, with 14 items per dimension, which is the most widely used, as it has the highest levels of internal consistency. Participants respond to the scale using a six-point format: strongly disagree (1), moderately disagree (2), slightly disagree (3), slightly agree (4), moderately agree (5), strongly agree (6). Responses to negatively scored items are reversed in the final scoring procedures so that high scores indicate high self-ratings on the dimension assessed.

Ryff (1989) does not specify any specific scores or cut-points for defining high or low well-being, but instead instructs that these distinctions be derived from distributional information from data collected on the scales. For example, Ryff explains that high well-being could be defined as scores that are in the top 25% of the distribution, whereas low well-being could be defined as scores that are in the bottom 25% of the distribution. Alternatively, high well-being

may be defined as scores that are 1.5 standard deviations above the mean, whereas low well-being may be defined as scores that are 1.5 standard deviations below the mean.

Individuals scoring higher on the dimension of *autonomy* are said to be self-determining and independent, are able to resist social pressures to think and act in certain ways, are able to regulate behavior from within, and are able to evaluate themselves by personal standards. This dimension was determined to have an internal consistency (coefficient alpha) of .83. Those scoring higher on the dimension of *environmental mastery* are thought to have a sense of mastery and competence in managing the environment, are able to control a complex array of external activities, are able to make effective use of surrounding opportunities, and are able to choose or create contexts suitable to personal needs and values. This dimension was determined to have an internal consistency (coefficient alpha) of .86. Higher scores on the dimension of *personal growth*, which was determined to have an internal consistency (coefficient alpha) of 0.85, are conceptualized as having a feeling of continued development, as they are able to see themselves as growing and expanding because they are open to new experiences, they have the sense of realizing their potential, they see improvement in self and behavior over time, and they change in ways that reflect more self-knowledge and effectiveness. The dimension of *positive relations with others* correlates to an individual having warm satisfying, trusting relationships with others, being concerned about the welfare of others, being capable of strong empathy, affection, and intimacy, and being able to understand the give and take of human relationships. Internal consistency (coefficient alpha) for this dimension was determined to be .88. Those scoring higher on the *purpose in life dimension* (internal consistency coefficient alpha = .88), are hypothesized to have goals in life and a sense of directedness, feel there is meaning to present and past life, hold beliefs that give life purpose, and have aims and objectives for living. Finally,

in the dimension of *self-acceptance*, those scoring higher are thought to possess a positive attitude toward the self, acknowledge and accept multiple aspects of the self, including good and bad qualities, and feel positive about their past life. Internal consistency (coefficient alpha) for this dimension was determined to be .91.

Questionnaire for Eudaimonic Well-being. The Questionnaire for Eudaimonic Well-Being (QEWB; Waterman et al., 2010) was developed to measure well-being in a manner consistent with how it is conceptualized in eudaimonist philosophy. Aspects of eudaimonic well-being assessed by the QEWB include self-discovery, perceived development of one's best potentials, a sense of purpose and meaning in life, intense involvement in activities, investment of significant effort, and enjoyment of activities as personally expressive. The QEWB was administered to two large (study 1, N=1728; study 2, N=5606), ethnically diverse samples of college students drawn from multiple sites across the United States. Participants were primarily female and Caucasian (over 50%) young adults with a mean age of 20. However, African Americans, Hispanic Americans, Asian Americans, and "other" ethnicities were also included.

The QEWB consists of 21 items covering the range of elements associated with eudaimonic well-being and consists of questions such as, "I can say that I have found my purpose in life" and "I believe I have discovered who I really am." The item statements are responded to on a 5-point Likert-type scale, with possible choices ranging from 0 (Strongly Disagree) to 4 (Strongly Agree). Cronbach's coefficient alpha was determined to be 0.86 and 0.85 for study one and study two respectively.

Social Well-Being Scale. In his article on social well-being, Keyes (1998) argues that in order to properly assess well-being, researchers must pay attention to the social as well as psychological aspects of well-being. As humans are social animals and live in conjunction with

others, they develop both private and public aspects of the self. Keyes posits that although less attention has been paid to the public aspect of the self, it is a major factor in well-being, as all individuals exist within a community. Keyes defines social wellness as an individual's evaluation of how they function in society, which consists of several dimensions, including social integration, social acceptance, social contribution, social actualization, and social coherence.

An important aspect of social well-being, *social integration*, consists of the extent to which one feels a commonality with others. Social integration emphasizes collective membership and the degree to which one feels a sense of belonging in their community. Alternatively, an individual may feel a sense of cultural estrangement from their community, which may lead to social isolation, as either they reject societal norms or feel that society rejects their values and lifestyle. This is an important concept for immigrant populations, as they may experience distress in terms of the acculturative stress they experience, especially when their foreign values do not match those of the host society.

Keyes (1998) argues that *social acceptance* consists of the ability for an individual to trust and be kind to others. Similar to the concept of self-acceptance, those with higher social acceptance accept both the good and bad aspects of society and others, contributing to a more complete view on human nature and mental health. The ability of an individual to make sense of both the good and bad aspects of themselves, may contribute to their ability to incorporate the duality of others.

Social contribution involves the evaluation of one's social value and their ability to contribute to society. This aspect of social well-being assumes that human beings are productive in nature, wishing to contribute to society. The absence of social contribution relates to

alienation, in which the individual does not perceive him or herself to be a productive member of society.

Social actualization involves the belief in the evolution of society and the ability to be hopeful that society is able to reach its potential. This concept involves the belief in the growth and development of society and relates to the growth and development of the self and openness to new experiences related to psychological well-being (Ryff, 1989). Social actualization is also related to eudaimonic well-being, as it entails the ability of society to understand its purpose and capitalize on this purpose in order to contribute to the greater good of society.

Social coherence involves an individual's ability to make sense of, organize, and understand their social world. It involves the ability of an individual to understand and accept the inevitable pitfalls of human existence and society. Individual's high in this aspect are able to make sense of and ultimately have a better ability to handle the inevitable tragedies and disappointments of life.

The Social Well-Being Scale was validated in two studies. The first study consisted of 373 adults living in Wisconsin (93% Caucasian and 59% female) and the second study consisted of 3032 adults from across the nation (84% Caucasian, 11% African American, 6% other, 57% female). The scale consists of 50 items (10 items per dimension) and respondents are asked to rate the degree to which they agree to each item on a Likert scale from one (strongly disagree) to seven (strongly agree). Keyes' (1998) five-factor theory of social well-being produced an excellent goodness of fit (0.95). In addition, the subscales were all found to intercorrelate positively with one another and were found to have relatively acceptable levels of internal consistency (with the exception of the scale of social acceptance, which showed an internal

consistency of 0.41, however the author hypothesized that this was due to adding in an extra item in the second study in order to balance the scale).

5-Factor Wellness Inventory. Sweeney and Witmer (1991) and Witmer and Sweeney (1992) developed the original Wheel of Wellness model, based on Individual Psychology, to inform the Wellness Evaluation of Lifestyle (WEL). The authors identified characteristics that correlated with well-being, including three major life tasks of work, friendship, and love and the two additional tasks of self and spirit. The model includes 12 subtasks of self-direction with spirituality as the core and hierarchically most important component of wellness. The tasks of self-direction provide the self-management necessary to successfully meet the life tasks of work, friendship, and love. Surrounding the individual in the Wheel of Wellness are life forces that affect personal wellness, including family, religion, education, business/industry, media, government, and community. After completing extensive research on the WEL, the authors concluded that their scale did not accurately fit their theory; therefore they reorganized their theory of wellness into The Indivisible Self (IS-WEL; Myers & Sweeney, 2005).

The IS-WEL, informed by Adlerian psychology, posits that the self is at the core of wellness and is indivisible. The components of the IS-Wel model are measured using the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005; Myers, Sweeney, & Witmer, 2000), with versions for adults (5F-Wel-A; Myers & Sweeney, 2005), middle school students (5F-Wel-T; Myers & Sweeney, 2005), and elementary school students (5F-Wel-E; Myers & Sweeney, 2005). The 5F-Wel is also available in languages other than English, as well as culturally adapted.

In this model of wellness, the indivisible self consists of five second order components. The first component, The Essential Self is comprised of four components: spirituality, self-care,

gender identity, and cultural identity. Both gender and cultural identity are conceptualized as filters through which life experiences are seen and as influenced upon how others are experienced. Self-care is conceptualized as proactive efforts to live long and live well.

The second component is the Creative Self, which is viewed as the combination of attributes that each individual forms to make a unique place among others in his or her social interactions (Adler, 1954; Ansbacher & Ansbacher, 1967). There are five components to this factor: thinking, emotions, control, positive humor, and work. The third component of the model, the Coping Self, consists of realistic beliefs, stress management, self-worth, and leisure. The Coping Self is composed of elements that regulate our responses to life events and provide a means for transcending their negative effects. The fourth component of the model is the Social Self, which includes friendship and love. Friendships and intimate relationships enhance the quality and length of one's life, as social support remains in multiple studies as the strongest identified predictor of positive mental health over the lifespan (Lightsey, 1996; Ulione, 1996). The fifth and final component is The Physical Self, which includes exercise and nutrition. This component was added as data suggests that individuals who live longest attend to both exercise and diet/nutrition (Bernarducci & Owens, 1996).

The model also includes contextual variables, as a complete understanding of the individual cannot be made without incorporating a concern for environmental factors. The authors hypothesized that the Indivisible Self is both affected by and has an effect on the surrounding world, therefore, the four contexts they considered to have an effect consisted of: local, institutional, global, and chronometrical.

The authors propose that each of the components of the Indivisible Self model interact with the others to contribute to holistic functioning. The contextual factors each have an

influence or impact on the individual and the individual affects his or her context. These interactions may be individual and collective. Strengths in any of the components can be mobilized to enhance functioning in other areas and to overcome deficits and negative forces which act to depress, demean, or deny the uniqueness and significance of the individual.

The Five Factor Wellness instruments are self-report inventories consisting of 95 to 98 items followed by a four point Likert response set: (1) strongly agree, (2) agree, (3) disagree, and (4) strongly disagree. Reading levels required for the adult, adolescent, and child versions are ninth grade, sixth grade, and third grade, respectively. The 5F-Wel-A (Adult) consists of 91 four-point Likert scale items and seven demographic items, the 5F-Wel-T (Teen) consists of 97 four-point Likert Scale items and one demographic item, and the 5F-Wel-E (Elementary) consists of 94 four-point Likert scale items and one demographic item.

The 5F-WEL-A is based on a normative sample of 3,343 adult participants ranging from 18 to 70 years of age with 29% being traditional university students. Males are underrepresented in the normative sample (35%) with a high proportion having a graduate degree. Caucasians (43.3%) and African Americans are overrepresented (27.5%), but other ethnic minorities are underrepresented: 1.6% Hispanic, 2.4% Native American, and 8.3% Asian.

The 5F-WEL-T is based on a normative sample of 1,142 adolescent participants ranging from ninth grade to 12th grade (14 to 18 years of age). Males comprised of 40.1% of the participants; females comprised of 41.2% of the participants, with 18.7% not reporting their gender. Ethnic minorities consisted of 33% of the sample; however, no specific data on the specific ethnic minority populations included was available. There are no normative sample demographics available for the 5F-WEL-E.

Internal consistency measures for the five factors were only available for the 5F-WEL-A, with alpha coefficients ranging from .89 to .96. The instrument yields a total wellness score with an alpha coefficient of .98. The 5F-WEL has been validated using structural equation modeling and further evidence of validity is provided by an extensive list of past research identified in the manual. Overall, there is adequate sample size and data to generalize results across the adolescent and adult versions; however, some caution may be warranted in use with underrepresented minorities.

Personal Well-Being Index. The Personal Well-Being Index was created from the Comprehensive Quality of Life Scale (ComQol; Cummins, McCabe, Romeo, & Gullone, 1994). The ComQol comprised both an objective and subjective measure of life quality. The ComQol domains were initially identified through a review of domain names used in the literature. However, the ComQol was abandoned due to major flaws. As a result, the Personal Well-Being Index (PWI) was developed in its place (Cummins, 2006).

The PWI (Cummins, 2006) was developed to measure the subjective dimension of quality of life, or subjective well-being, and contains eight items of satisfaction, each one corresponding to a quality of life domain, specifically: standard of living, health, achieving in life, relationships, safety, community-connectedness, future security, and spirituality/religion. These eight domains are designed to measure the global question of how satisfied one is with their life as a whole. Cronbach's alpha for the scale lies between .70 and .85. The index has also demonstrated good test-retest reliability across a 1-2 week interval with an intra-class correlation coefficient of 0.84. A correlation of .78 with the Satisfaction With Life Scale (SWLS) has been reported by Thomas (2005). Participants are asked to respond to questions based on a scale of

zero (completely dissatisfied) to 10 (completely satisfied). The responses are then combined to give a percentage score out of 100.

In 2002, Cummins and Lau initiated the International Wellbeing Group (IWbG; Cummins & Lau, 2003) with the objective of developing the PWI into a valid cross-cultural instrument. As of 2005, over 100 researchers from 50 countries and provinces were engaged in the collaboration. The PWI is available in several different formats and languages, including, adult (over 18), school-aged/adolescent, pre-school aged, and those with intellectual disabilities or cognitive impairments. The PWI has also been translated into Arabic, Chinese, Tibetan, Croatian, Dutch, Italian, Japanese, Spanish, Norwegian, Farsi, Russian, and Slovakian.

Satisfaction With Life Scale. The Satisfaction With Life Scale (SWLS) is a measure of life satisfaction developed by Ed Diener and colleagues (Diener, Emmons, Larsen & Griffin, 1985). Diener conceptualizes life satisfaction as one factor in the more general construct of subjective well-being. Diener suggests that subjective well-being has at least three components, positive affective appraisal, negative affective appraisal, and life satisfaction. Life satisfaction is distinguished from affective appraisal in that it is more cognitively than emotionally driven. Life satisfaction can be assessed specific to a particular domain of life (e.g., work, family) or globally.

The SWLS is a five-item scale that is designed to measure global cognitive judgments of satisfaction with one's life. Individuals indicate their degree of agreement or disagreement on a seven-point Likert-type scale. Diener et al. (1985) reported a two-month test-retest correlation coefficient of .82 and an alpha coefficient of .87 for a sample of 176 undergraduates. In a sample of 39 elderly individuals, Pavot, Diener, Colvin, and Sandvik (1991) obtained an alpha coefficient of .83. The SWLS has been found to be positively associated at statistically

significant levels with other measures of subjective well-being and negatively associated with measures of psychopathology (Diener et al., 1985).

Flourishing Scale and Scale of Positive and Negative Experience. The Flourishing Scale (FS; Diener et al., 2009) consists of eight items describing aspects of human functioning ranging from positive relationships, to feelings of competence, to having meaning and purpose in life. Each item of the FS is answered on a seven-point Likert scale ranging from one (Strong Disagreement) to seven (Strong Agreement). All items are phrased in a positive direction and scores can range from eight (Strong Disagreement with all items) to 56 (Strong Agreement with all items). High scores signify that respondents view themselves in positive terms in important areas of functioning. Although the scale does not separately provide measures of facets of well-being, it does yield an overview of positive functioning across diverse domains that are widely believed to be important.

The Scale of Positive and Negative Experience (SPANE; Diener et al., 2009) is a brief 12-item scale, with six items devoted to positive experiences and six items designed to assess negative experiences. Because the scale includes general positive and negative feelings, it assesses the full range of positive and negative experiences, which include specific feelings that may have unique labels in particular cultures. Because of the general items included in the scale, it can assess not only the pleasant and unpleasant emotional feelings that are the focus of most scales, but also reflects other states such as interest, flow, positive engagement, and physical pleasure.

Each SPANE item is scored on a scale ranging from one (“very rarely or never”) to five (“very often or always”). The positive and negative scales are scored separately because of the partial independence of the two types of feelings. The summed positive score (SPANE-P) can

range from six to 30, and the negative scale (SPANE-N) has the same range. The two scores can be combined by subtracting the negative score from the positive score, and the resulting SPANE-B scores can range from negative 24 to positive 24.

Both scales were validated in a sample of 689 college students from six locations. The FS was found to have good psychometric properties (Cronbach's $\alpha = 0.87$), and was strongly associated with other psychological well-being scales. The SPANE was also found to converge well with measures of emotions and affective well-being (Cronbach's $\alpha = 0.87, 0.81, 0.89$, for the positive, negative, and balance scales respectively).

Positive And Negative Affect Schedule. The Positive And Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) consists of two 10-item mood scales and was developed to provide brief measures of positive and negative affect. Respondents are asked to rate the extent to which they have experienced each particular emotion within a specified time period, with reference to a five-point Likert scale, ranging from one (very slightly or not at all) to five (very much). The reliability of the Positive Affect scale ranged from .86 to .90 and the Negative Affect scale from .84 to .87.

World Health Organization (WHO)-Five Well-Being Index (WHO-5). The WHO-5 is a short version of the WHO Well-Being Scale, which was initially developed to evaluate the quality of care for diabetic patients (WHO, 1990). The WHO-5 is a self-administered five-item scale. Each item assesses the degree of positive well-being during the past 2 weeks, covering positive mood (good spirits, relaxation), vitality (being active and waking up fresh and rested), and general interests (being interested in things; Bech, 1998, 2001). Each of the five items is rated on a six-point Likert scale ranging from zero (at no time) to five (all of the time), and the total raw score ranges from zero to 25, with higher scores indicating an increased sense of well-

being. In order to monitor possible changes in well-being, a percentage score must be determined. The percentage value is obtained by multiplying the score by four. A 10% difference indicates a significant change in well-being.

The scale has been translated into various languages and validation data has been published in the context of various health conditions, including depressive disorders, anxiety disorders, cognitive impairment and dementia, and psychiatric disorders, in addition to the health-related quality of life. Discriminatory validity as a screening tool for depressive disorders has also been examined. Bonsignore, Barkow, Jessen, and Heun (2001) reported good internal (Loevinger's coefficient = 0.47; Mokken coefficient > 0.4 in all items) and external validity (ROC analysis showed adequate detection of depression; Area Under Curve=0.886, Confidence Interval=.819-.995) of the WHO-5 in detecting depression in the elderly population.

Limitations of Current Measures

Existing models and measures of well-being lack an integration of the significance of community, culture, and spirit and tend to have an individualistic, Western cultural bias. Furthermore, these measures have not explicitly incorporated cultural variability and contextual influences on the experience of well-being with respect to item content or scale structure. Conceptualizations of well-being have been operationalized and measured internationally rather than developing the construct of well-being in a way that integrates culture and context in the conceptualization and creating a scale that is multicultural. Therefore, the current conceptualizations of well-being fail to recognize cultural variety and dynamics within. At the time of this review, there is also a lack of a multiculturally validated, comprehensive measure incorporating multidimensional aspects of well-being.

Culture and well-being. Current research on well-being across varying ethnic groups has revealed important considerations regarding the conceptualization of well-being (e.g., Diener, Diener, & Diener, 1995; Diener & Suh, 1997; Diener & Suh, 1999; Diener, Suh, Lucas, & Smith, 1999; Suh, Diener, Oishi, & Triandis, 1998). Interestingly, many studies have revealed distinct differences in well-being between individualistic and collectivistic cultures. Although it should also be noted that the research on collectivistic cultures has almost exclusively been conducted on East Asian groups; therefore, there is very little empirical data on well-being in Middle Eastern, African, Native American, South American, Caribbean and other collectivistic cultures. Additionally, because subjective well-being is dependent on values, and societies place different values on what is important to them, comparing well-being cross-culturally based on current conceptualizations is quite difficult. Further complicating the picture, western cultures have a global positive response tendency, whereas eastern cultures do not, accounting for some potential differences (Diener et al., 1999). Lastly, as most well-being studies are correlational and cross-sectional in design, causality is difficult to determine. Nevertheless, relevant findings from cross-cultural studies on well-being are important to examine and will be explored in further detail below.

Studies have shown that self-esteem and self-consistency were found to be important in western cultures, but not as important in East Asian cultures (Diener & Diener, 1995; Kwan, Bond, & Singelis, 1997). Furthermore, whereas individualists use their emotions to judge their life satisfaction, collectivists rely more on social appraisals to judge life satisfaction (Suh et al., 1998). Autonomy has also been found to be positively correlated with well-being in nations identifying strongly with individualism (i.e., United States, Australia, Germany, and Finland), but not in nations identifying strongly with collectivism (i.e., 14 nations from Asia, 5 nations

from South America, and 5 nations from Africa; Oishi, 2000). Despite differences, positive social relationships were found to be important in both individualistic and collectivistic cultures (Oishi, 2000).

Emotions and behaving according to the norms of society were also found to predict subjective well-being in collectivistic cultures (Diener, Suh, & Oishi, 1997). Expectations were also found to be important in determining subjective well-being. Asian cultures, noted to have high aspirations and expectations, may not realize their hopes, leading to decreased subjective well-being. When expectations are low and/or when people have low levels of desires for things that require resources their subjective well-being will be high (Diener, 2000). Interestingly, some cultures were found to have superstitions against reporting that they were happy, believing that it would bring unfortunate events, correlating to lower levels of reported subjective well-being (Lyubomirsky, 2001).

In tight societies, where collectivism is high and deviations from the norm are less tolerated, individuals tend to report increased anxiety while subjective well-being is rated lower (Triandis, 2000). Furthermore, the frequencies of fantasies are also higher in tight societies, because, through fantasy, society members do not need to be as concerned about how their behavior will affect others in their family or community (Triandis, 2000). However, too many pleasant fantasies can also lead to a decreased sense of subjective well-being, as fantasies do not often match up with reality (Triandis, 2000). In other words, individuals are prone to be happier if they have moderately positive experiences rather than many positive fantasies, as many positive fantasies leads to a less positive reality in comparison and a decreased sense of subjective well-being.

Tight cultures also have more rules regarding comparisons, as individuals from tight cultures have less flexibility with whom they can compare themselves to (Triandis, 2000). In simple cultures, what it means to “turn out well” is more limited (e.g., many cultures believe that achieving high levels of education is the only road to success), therefore there is likely to be more dissatisfaction with the way children turn out, leading to decreased subjective well-being (Triandis, 2000). On the other hand, because of this limited view, children from these cultures are more prone to accomplish what is expected of them, thereby increasing their subjective well-being (Triandis, 2000). Few choices and few comparison others is thought to lead to low subjective well-being. Furthermore, approval from others, especially parents, increases subjective well-being in collectivistic cultures (Triandis, 2000).

Several studies have also found that when culture and personality are consistent and when there is strong identification with one’s cultural group, subjective well-being is perceived to be higher. However, when individuals from a collectivistic society are immersed into an individualistic nation, stress may also be increased (Cross, 1995) and well-being compromised.

Integrative and Critical Summary

As noted previously, a multiculturally validated, comprehensive measure incorporating multidimensional aspects of well-being has yet to be developed. Furthermore, most measures have an individualistic, Western viewpoint and are not inclusive of aspects noted to be pertinent to the well-being of those from collectivistic cultures, such as community, culture, and spirit. In addition to having a limited conceptualization of well-being, most scales have been validated in predominately young (i.e., college-aged), Caucasian, highly affluent, and highly educated populations within the U.S. Although some scales have attempted to gain cross-cultural validity,

their efforts have mainly been accomplished through gathering international data, rather than collecting a diversity of samples within the same nation.

Because the U.S. is a country comprised of an abundance of diversity, including a plethora of immigrant populations from various regions of the globe, the significance of understanding the mental health and well-being of a variety of populations is ever-prominent. Studies reviewed above attempting to accomplish this goal have significant limitations in that they utilized individualistic-biased measures that have limited cross-cultural validity (e.g., SWB). Furthermore, although some literature on the interaction between immigration, acculturation, enculturation, and well-being exists, results are also based on an individualistic approach to well-being. Therefore, the impact of measuring these variables with a multiculturally validated measure of well-being may produce important findings on our understanding of the overall health of these individuals.

Chapter III. Methodology and Procedures

Participants

The target sample size was determined based on power tables developed by Cohen (1992), considering the number of variables used for statistical analysis. For a t-test for the difference between two independent means with $df=2$, the required sample size is 64, with medium effect size and power set at .80 (Cohen, 1992). Therefore, a minimum of 64 participants was required.

Inclusion criteria for participation in the study consisted of the following: (a) participants must be 18 years or older; (b) participants must be able to read and understand English; (c) participants must provide consent to be included in the research database; and (d) participants must have at least one parent born in Iran or self-identify as Iranian/Iranian-American or Persian/Persian-American. Participants may have any immigration status (first generation, second generation, refugee, etc.) and are expected to reflect diverse religious and socioeconomic backgrounds. There were no exclusion criteria. Anyone meeting the inclusion criteria was eligible to participate in this study.

Recruitment Procedures

The study used a non-random sampling method for data collection. Since the focus of the study was on Iranians, the sample selection used was purposive sampling in order to recruit the desired participants for the study. After receiving approval by the Institutional Review Board, the researcher used a non-random distribution method to solicit participants.

The methodology for this study was derived from a larger psychometric study of Harrell's Multidimensional Well-Being Assessment (MWA) instrument. Participants for the current study were recruited from organizations with a high number of individuals of Iranian descent, such as the Iranian-American Muslim Association of North America (IMAN) Cultural

Center, the Persian Cultural Center (PCC), the Iranian Student Group (ISG) at the University of California Los Angeles (UCLA), the Iranian Student Union (ISU) at the University of California Irvine (UCI), and the Pepperdine Iranian Psychological Student Association (PIPSA).

The researcher contacted leaders of the different organizations to obtain permission to either distribute the questionnaires at organization meetings or disseminate flyers with information directing potential participants to take the questionnaire online (see Appendix A). The researcher also contacted organization leaders to obtain permission to email organization list-serves with information on the study and a link to take the questionnaire online or make announcements on online blog and social network sites with a link to take the questionnaire online (see Appendix B). The researcher additionally utilized a snowball sampling procedure by attending organization meetings and encouraging organization members to recruit other Iranians to complete the questionnaires by handing out flyers with information on where they would be able to take the questionnaire (see Appendix C). The project's online presence served as a primary recruitment setting. This included the project website at <http://wellbeingresearch.net> and Facebook page at <http://www.facebook.com/wellbeingresearch>.

Every participant who completed the research study additionally had the option of being entered into a Prize Drawing for a \$30 gift certificate from GiftCertificates.com. An email address was requested from participants who completed the study online or who completed a paper version individually. Winners were sent an electronic gift certificate to their choice of over 100 retailers including stores, restaurants, and movie theaters.

Design

This non-experimental study utilized a cross-sectional correlational design to examine both the reliability and validity of the MWA and the relationship of dimensions of well-being to several demographic variables. The outcome variables were the five wellness context areas and 15 dimensions of well-being measured by the MWA (*Psychological Well-Being Context* [YWB] with four dimensions: Emotional Dimension [YWB-E], Functional-Behavioral Dimension [YWB-F], Awareness Dimension [YWB-A], Transformational Dimension [YWB-T]; *Relational Well-Being Context* [RWB] with two dimensions: Prosocial Dimension [RWB-P] and Relationship Quality Dimension [RWB-Q]; *Collective Well-Being Context* [CWB] with four dimensions: Sociocultural Identity Dimension [CWB-I]; Community Dimension [CWB-C]; Participatory Dimension [CWB-P]; National Context Dimension [CWB-N]; *Transcendent Well-Being Context* [TWB] with two dimensions: Spiritual-Religious Dimension [TWB-S] and Meaning-Purpose-Flow Dimension [TWB-M]; *Physical Well-Being Context* [PWB] with three dimensions: Safety Dimension [PWB-S], Health and Body Dimension [PWB-H], Environmental Dimension [PWB-E]). The predictor variables of gender, age, length of time in the U.S., birth country, student or occupation status, marital status, child and elderly caregiver stats, religion, level of education, and socioeconomic status, were determined through a demographic questionnaire and other instruments.

Instrumentation

Demographics questionnaire. The demographic questionnaire was developed by Harrell et al. (2013) for the larger MWA psychometric study and consists of questions that focus on the general background of the participants, including items regarding gender, age, marital and relationship status, place of birth, parent's place of birth, length of time living in the United

States, child or elderly caregiver status, ethnic identification, religious affiliation, living arrangements, level of education, financial status, work or student status, occupation, illness or medical conditions, and levels of perceived stress (i.e., within a two week period – less than usual, about the same as usual, or more than usual).

Multidimensional Well-Being Assessment (MWA). The MWA was developed by Harrell et al. (2012) for the primary purpose of contributing an instrument to the measurement of well-being that is comprehensive and more inclusive of aspects of well-being that may be particularly relevant to racial/ethnic minority groups and those of lower socioeconomic status. In particular, the MWA is the first well-being measurement to include transformational well-being, collective well-being and transcendent well-being within a comprehensive assessment of the construct. Despite the availability of numerous scales of related constructs, conceptualizing well-being inclusive of these ideas and measuring the resulting multidimensional construct in a single efficient instrument is the unique contribution of the MWA.

Development of the MWA was informed by guidelines for scale construction offered by DeVellis (2012) and Clark and Watson (1995). A comprehensive literature review on the construct of well-being, measures of well-being, and well-being in diverse racial-ethnic groups was conducted that resulted in the Multidimensional-Contextual Model of Well-Being (Harrell et al., 2012) positing five core life contexts within which well-being is experienced: Relational, Collective, Transcendent, Psychological, and Physical. A qualitative study on well-being among homeless men in a substance-abuse program (Nathan, 2010) also informed the development of the conceptual framework, particularly the decision to include a dimension of psychological well-being related to the sense that one is in the process of growing and becoming a better person (transformative well-being). An exhaustive pool of items was systematically generated for

consideration that reflected the literature and was consistent with the conceptual model. These items were evaluated by an open-discussion content validation process with a culturally diverse group of doctoral and master's level students in psychology familiar with both multicultural psychology and the well-being literature. The number of items were reduced and assigned to theoretically-derived well-being dimensions using a Q-sort procedure. A preliminary scale was developed and piloted in a sample of 60 African American women in prison (Grills et al., 2012) where it performed well in statistical analyses.

Additional literature review and content validation discussion resulted in the addition of dimensions within the Collective and Physical wellness contexts resulting in a final 160-item scale with five primary wellness contexts, and fifteen well-being dimensions (two to four within each context). These include the Psychological Wellness context comprised of four dimensions of well-being (Emotional, Functional, Transformational, and Awareness), the Physical Wellness context comprised of three dimensions of well-being (Health and Body, Environmental, and Safety), the Relational Wellness context comprised of two dimensions of well-being (Prosocial and Relationship Quality), the Collective Wellness context comprised of four dimensions of well-being (Community, Sociocultural Identity, Participatory, and National Context) and the Transcendent Wellness context comprised on two dimensions of well-being (Meaning-Purpose-Flow and Spiritual-Religious).

Items are rated on a six point Likert-type scale. The respondent is asked to rate each item based on how much the statement has been true for them over a specific time frame (e.g., past two weeks). Responses range from "Never/Not at all" to "Always/Extremely." Participants are also given the option to respond to items with "N/A or does not apply to me" (i.e., the statement doesn't relate to my life at all); however, participants are asked to only use this response option

for items that do not pertain to them or make sense to them at all. Scores are calculated for each Wellness Context, as well as for each dimension of well-being by adding the ratings and dividing by the number of items so that scores are comparable across domains and dimensions.

A large psychometric study is currently being implemented with a goal of racial/ethnic and socioeconomic diversity in the validation sample. The sample size goal is 700 participants in order to conduct a factor analysis for a more thorough examination of the structure of the MWA. The MWA has been translated into Spanish, and will be translated into Korean and Farsi in the future, so that initial psychometric data can include a broad diversity of participants for whom English is not their first language.

A preliminary analysis of the data reflecting the responses of the first 94 participants who participated in the psychometric study and completed an online questionnaire that included demographic questions and the MWA (63 of which also completed a set of validation instruments) revealed highly promising results with respect to the psychometric properties of the measure (Harrell et al., 2013). Participants included in the preliminary analysis consisted of mostly females (76.6%) with a mean age of 36.7 years ($SD=13.1$), ranging from 18-57 years old. Over half of the participants (53.2%) consisted of People of Color, including Latino, Asian, Persian/Iranian, African American, Middle Eastern, and Multiracial. They also reflected a diverse immigration status background, as 12% moved to the U.S. as a child and 11% moved to the U.S. as an adult. The majority of the population had obtained a college degree or higher (81%), with 19% having a high school or vocational degree.

Reliability coefficients for the five contexts and 15 dimensions of the MWA ranged from .70-.96. There was a significant positive correlation between the five wellness contexts of the MWA and the Flourishing Scale (Diener et al., 2009) and the Positive Emotion subscale of the

SPANE (Diener et al., 2009). There was additionally a significant negative correlation between the five wellness contexts and the Negative Emotion subscale of the SPANE (Diener et al., 2009). Women had significantly higher scores on the Relationship Quality dimension of well-being than men (Harrell et al., 2013). Those who moved to the U.S. as an adult had significantly higher Collective Identity scores than both those born in the U.S. and those who moved to the U.S. as a child (Harrell et al., 2013). People of Color had significantly lower subjective well-being, lower total Physical Well-Being, and higher negative emotions than Whites (Harrell et al., 2013). Participants whose highest level of education was a high school degree or vocational school had significantly higher scores on the Collective-Participatory dimension of well-being than those with a college or graduate degree (Harrell et al., 2013). The pattern of relationships reflected in the validity coefficients and differences between groups suggested strong construct and known-groups validity (Harrell et al., 2013).

Broad Assessment of Distress and Dysfunction (BADD). The BADD (Harrell et al., 2013) was originally developed by Harrell in 1997 as a measure of general experiential distress and problems in life. Items were updated and reworded in 2011. The purpose of scale development was to address a gap in current scales and create a measure of subjective distress that was not focused on a specific diagnostic category or particular symptom clusters. The items were designed to tap into a wide range of ways that people experience and express their distress with items worded in non-clinical language using phrasing that represent general ways that lay people express their distress (e.g., “I felt overwhelmed by the stress in my life”, “I felt like a failure, a loser”; “I felt like life was really unfair to me”; “I felt like I was going crazy, like I was losing my mind”; “I did things that I felt bad about”). The instrument is comprised of 36 items that are rated on a five point Likert-type scale. The respondent is asked to rate the item based on

how much the statement has been true for them over a specific time frame (e.g., past week, past 2 weeks, past month). Responses range from “Never true for me” to “Always true for me”. The total score is calculated as a sum of ratings across the 36 items. Psychometric properties will be established in the larger MWA psychometric project.

Personal Well-Being Index (PWI). The PWI (Cummins, 2006) contains eight items of satisfaction, each one corresponding to a quality of life domain, specifically: standard of living, health, achieving in life, relationships, safety, community-connectedness, future security, and spirituality/religion. These eight domains are designed to measure the global question of how satisfied one is with their life as a whole. Cronbach alpha for the scale lies between .70 and .85. The index has also demonstrated good test-retest reliability across a 1-2 week interval with an intra-class correlation coefficient of 0.84. A correlation of .78 with the SWLS has been reported by Thomas (2005). Participants are asked to respond to questions based on a scale of 0 (completely dissatisfied) to 10 (completely satisfied). The responses are then combined to give a percentage score out of 100.

Satisfaction With Life Scale (SWLS). The SWLS (Diener et al., 1985) is a five-item scale that is designed to measure global cognitive judgments of satisfaction with one's life. Individuals indicate their degree of agreement or disagreement on a seven-point Likert-type scale. Diener et al. (1985) reported a two-month test-retest correlation coefficient of .82 and an alpha coefficient of .87 for a sample of 176 undergraduates. In a sample of 39 elderly individuals, Pavot et al. (1991) obtained an alpha coefficient of .83. The SWLS has been found to be positively associated at statistically significant levels with other measures of subjective well-being and negatively associated with measures of psychopathology (Diener et al., 1985).

Data Collection Procedures

The project's online presence served as a primary recruitment setting. The researcher contacted organization leaders and was able to obtain permission to email organization lists with information on the study and a link to take the questionnaire online and/or make announcements on online blog and social network sites with a link to take the questionnaire online (see Appendix B). All potential participants were informed in the "Information for Research Participants" section of the online study document (see Appendix B) that their participation was strictly voluntary and that there were no negative consequences for choosing not to participate or ceasing participation at any time.

Compensation. At the end of the online questionnaire administration each participant was given the choice of providing an email address for entry into the weekly Prize Drawing or submitting their questionnaire without entering the drawing. Online participants who completed the General Information Questionnaire and the MWA only received one entry in the Prize Drawing for that week. Online participants who chose to complete the additional validity instruments received five entries into that week's Prize Drawing. The prize drawing entry form also requested their initials and state of residence for project records. This data was inputted into a specific Prize Drawing database. This information was immediately separated from the completed questionnaire and filed separately.

Each week, the drawing was held for a combination of online participants and participants who returned a paper copy of the questionnaire (as part of the larger MWA database). The drawings were held weekly every Tuesday for participants whose completed questionnaires were received the previous week before 11:59pm on Sunday. Completed questionnaires, in which email addresses were provided, received each week between 12:00am

the previous Monday morning and 11:59pm the Sunday evening before the drawing was entered into the drawing held every Tuesday.

The prize drawing procedure involved a random selection process within the separate Prize Drawing database using the Statistical Package for the Social Sciences (SPSS) random number generator. Each email address was assigned a number and then a random number was requested to identify the winner. The winner was sent an email from the project staff to inform them that they have won and to confirm their email address. After confirmed, Giftcertificates.com was provided with the email address of the winner each week and the winner was automatically sent an electronic gift certificate. Participants were informed that entering the prize drawing requires Giftcertificates.com to have their email address solely for the purposes of distribution of the gift certificate and that they will not have any further contact with the participant unless there is a problem with the certificate delivery. Giftcertificates.com was not provided with the participant's initials, state of residence, or any data from completed questionnaires. Each week's winners were sent a follow-up email from the research project staff no more than 24-hours from distribution of the certificate from Giftcertificates.com. If the certificate was not received then research staff voided the original certificate number with giftcertificates.com and had another certificate sent to the winner. All participants who were entered in the weekly drawing were sent an email announcing the winner's initials and state of residence every Wednesday after the drawing was held. Announcement of winners was also listed on the project website. The rationale for announcing winners was to maintain the credibility of the project so that people who participate were assured that, indeed, a drawing was held that week and that a gift certificate was distributed.

Chapter IV. Results

Participant Demographic Information

A total of 77 participants met inclusion criteria for the study. Of the 77 participants who met inclusion criteria, only 62 (N=62) completed the MWA (81%), and 19 completed the entire study, including selected validation scales (25%). Participants who completed the MWA consisted of 35 females (56.5%) and 27 males (43.5%). Ages of participants ranged from 18 to 72 with a mean age of 37.58 (SD=15.04). Approximately 60% (N=37) of participants were born in Iran, while 39% were born in the U.S. and the remaining 1% born in a different country (i.e., India). Of those that were born in Iran, over half (56%) moved to the U.S. after the mid-1980's (i.e., fourth wave immigrants), 30% moved to the U.S. from 1978-1984 (i.e., third wave immigrants), 11% moved to the U.S. from 1970-1978 (i.e., second wave immigrants), and only 3% moved from 1950-1970 (i.e., first wave immigrants). All participants had either one or both parents born in Iran, with the majority having both born in Iran (94%). Ninety-five percent of participants were currently living in the U.S. (with the remainder living in Iran) and primarily resided in Southern California. Time spent living in the U.S. ranged from one to forty-five years with a mean of 25.76 years (SD=8.73).

About half of participants (53.2%) identified as Jewish, 32.3% as Muslim, 4.8% as Christian (i.e., Protestant, Non-denominational, or Catholic), and the remaining 9.6% identified as either spiritual with no specific religious belief system, Agnostic, or Atheist. When asked to describe racial-ethnic-cultural identity in their own words, responses varied, as 25.8% of participants self-identified as "Iranian American," 22.6% as "Persian (or Iranian) Jewish" or "Persian (or Iranian) Jewish American," 21% identified as "Persian," 14.5% as "Iranian," 11.3%

as “Persian American,” and the remaining 4.8% as other, including either “Armenian American,” “Lebanese Canadian American,” or “Multiracial with Middle Eastern/Persian background.”

The majority of participants had obtained a college or university degree or higher (38.7% college or university degree; 32.3% graduate or professional degree), while 12.9% had obtained a community college/vocational/trade school degree, 14.5% a high school degree or equivalent, and 1.6% with some high school or less. About half of participants were currently students (46.8% either part time or full time students). Most were working either full time or part time (43.5% full time; 19.4% part time), 32.3% were not currently working by choice, and the remainder was looking for a job (4.8%).

Response varied with regard to occupation, however most were concentrated in the following categories: high skill professionals (i.e., physician, dentist, psychologist, engineer; 22.6%), 16% held business/office administration positions (e.g., administrative assistant, office manager), 13% were homemakers or retired, and 9.7% were in real-estate or sales.

Most participants listed an annual income in the \$50,000-\$100,000 range (38.7%), 29% had an annual income of over \$100,000, while 12.9% fell in the \$25,000-\$50,000 range, and 19.4% made less than \$25,000. Only 12.9% of participants noted that solely their basic needs were being met (with no extras), while 30.6% had everything they needed plus a few extras, 29% were able to purchase many of the things they wanted, and 27% were able to buy luxury items or buy nearly anything they wanted.

Half (50%) of the population was single and had never been married, 33.9% were currently married, and 9.7% were divorced. About half of participants were either in a permanent relationship with their life partner (37.1%) or in an intimate relationship with their boyfriend/girlfriend (9.7%), while the other half were either not currently dating (21%) or

casually dating (i.e., dating but not currently in a relationship; 32.3%). Those who were currently caregivers for children under the age of 18 consisted of 19.4% of participants. An additional 19.4% were currently primary caregivers for an elderly individual.

The majority of the population was healthy; however, 19.4% endorsed being negatively impacted by an illness or condition that affected their lives. The most common conditions or illnesses participants endorsed consisted of: sleep disorders (19.4%), high blood pressure, cholesterol, or obesity (16%), chronic back pain (14.5%), migraines or headaches (8.1%), or Major Depression, Anxiety, Phobias, or Post-Traumatic Stress Disorder (8.1%). The majority of participants rated themselves as experiencing the same amount of subjective stress as usual over the past two weeks (69.4%), while 21% of individuals had experienced more stress than usual, and 9.7% as less stress than usual.

Data Analysis

The Statistical Package for the Social Sciences (SPSS) version 22.0 was utilized to analyze the data in this study. Participant responses were coded and entered into the SPSS database by the researcher. The data analysis process involved preliminary and descriptive analyses, internal consistency reliability analysis, correlational analyses to examine validity, and a series of t-tests, bivariate correlations, and one-way analysis of variance (ANOVA) to determine relationships and the significance of mean group differences between the five contexts and 15 dimensions of well-being within the sample of adults of Iranian descent.

For preliminary and descriptive analyses, the first step of analysis consisted of cleaning the data by assessing missing data, frequencies, means, modes, and measures of error for each item. Missing data was replaced with a mean substitution process for that item. This process led to any necessary corrections of data entry errors and the identification of any outlier scores.

Next, a descriptive analysis of the demographic variables as well as the scores for the well-being contexts and dimensions were computed. The frequencies, range, means, and standard deviations were obtained for all demographic variables and scores on the MWA dimensions and items, BADD, PWI, and SWLS.

The researcher then ran a series of bivariate correlations (i.e., Pearson's r correlations) among all variables, in order to observe patterns of relationships and any potential implications for exploring the research questions. The researcher also ran a correlation between the MWA, BADD, PWI, and SWLS to examine the validity of the MWA. Cronbach's alpha tests were performed on each of the five MWA contexts and 15 dimensions in order to assess internal consistency reliability.

The researcher next examined intragroup variability within the Iranian sample using correlations, t-tests, and ANOVA's to look for any significant differences between different levels of the categorical demographic variables and the well-being contexts and dimensions. Bivariate correlations were used to determine relationships and predictors of well-being on several demographic variables. To account for multiple testing and control for type I error, a pseudo-Bonferroni adjustment was applied. Thus, statistical significance was set at an alpha of 0.01 rather than 0.05.

Preliminary Analysis

Data cleaning. All of the variables were cleaned by assessing the frequencies, means, and minimum and maximum scores. Several missing items were found and corrected with a mean substitution for that item. There were no significant outliers found in the data set.

Data selection. Frequencies were assessed for gender, age, sexual orientation, marital and relationship status, place of birth, parent's place of birth, length of time living in the United

States, child or elderly caregiver status, ethnic identification, religious affiliation, level of education, financial status, work or student status, occupation, illness or medical conditions, and levels of perceived stress, to examine the general tendencies of the data and to determine how to select cases for the present study. The study participants were diverse in terms of the majority of these variables. Therefore, the following variables were selected to examine: age, length of time living in the U.S., gender, birthplace, religion (selecting two categories of Jewish or Muslim), students and non-students, currently married and non-married, currently single and non-single, elderly or parent caregivers, those who endorsed being negatively impacted by an illness or health condition, those who fell into three education categories of having obtained less than a college degree, a college degree, or a graduate/professional degree, those who fell into the three work categories of full-time, part-time, or not working by choice, those who selected any of the four relationship status categories, those who fell into four financial status categories and four income categories, and three levels of perceived stress.

Internal Consistency Reliability Analysis of the MWA

Internal consistency reliability analyses were conducted and Cronbach's alphas were determined for each context and dimension of the MWA. Table 1 presents the results for the MWA contexts and dimensions as well as mean and standard deviation scores for each context and dimension.

All of the five MWA Contexts demonstrated strong reliability (ranging from .873-.936). Most (12) MWA Dimensions also demonstrated strong reliability (ranging from .731-.899), with the exception of three dimensions: Psychological-Awareness, Collective-Participatory, and Collective-National (ranging from .581-.694).

Table 1

Reliability Coefficients and Mean Values for the MWA Contexts and Dimensions

Context and Dimension	# Of Items	Cronbach's Alpha	Mean (SD)
Physical	31	.882	4.24 (.56)
Health	12	.731	3.91 (.62)
Environment	11	.776	4.19 (.66)
Safety	8	.807	4.81 (.76)
Psychological	40	.936	3.63 (.61)
Emotional	12	.878	3.77 (.72)
Functional	10	.781	3.75 (.66)
Awareness	6	.611	3.53 (.69)
Transformative	12	.793	3.44 (.65)
Relational	27	.873	3.76 (.58)
Relationship Quality	15	.830	3.90 (.68)
Prosocial	12	.775	3.59 (.61)
Collective	35	.890	3.42 (.63)
Identity	12	.853	3.66 (.79)
Community	10	.769	3.60 (.74)
Participatory	8	.694	3.14 (.87)
National	5	.581	2.92 (.88)
Transcendent	27	.908	3.13 (.75)
Meaning	14	.793	3.38 (.65)
Spirituality	13	.899	2.85 (1.0)

Removing specific items with lower item-total correlations from several dimensions significantly improved the alpha for the dimensions listed in Table 2, particularly for the three dimensions that did not show strong initial reliability. However, removing items from the remainder of the following five dimensions did not improve the alpha: Physical-Environment, Psychological-Emotional, Relational-Relationship Quality, Collective-Community, and Transcendent-Spirituality.

Table 2

Alphas if Item Deleted for Dimensions

Context and Dimension	Item #	Alpha Before Deletion	Alpha if Item-Deleted
Physical			
Health	48	.731	.751
Safety	89	.807	.829
Psychological			
Functional	19	.781	.808
Awareness	93	.611	.664
Transformative	102	.793	.801
Relational			
Prosocial	47	.775	.785
Collective			
Identity	109	.853	.856
Participatory	6	.694	.701
National	126	.581	.601
Transcendent			
Meaning	70	.793	.802

Therefore, in this preliminary analysis of reliability for the MWA contexts and dimensions in an Iranian sample, the following items may not be reliable to assess for the particular dimensions detailed in Table 2 and will, thus, need to be further monitored in future studies with a larger sample size: “(48) I was satisfied with my sexual functioning and activity,” “(89) I felt safe from sexual violence or exploitation,” “(19) I spent time doing my hobbies, special projects, or other activities that I enjoy,” “(93) I stopped to pay attention to what I was feeling emotionally and/or physically,” “(102) My neighborhood or local community was an important part of my life,” “(47) I supported someone in getting through a difficult situation,” “(109) I displayed my identification with my culture or another important identity group (symbols, clothing, language, artwork, home décor, bumper stickers, etc.),” “(6) I did something to help make the world a better place,” “(70) I felt connected to the rhythms and patterns of

nature (e.g., animals, trees, oceans, stars, mountains, or other living things),” and “(126) I felt committed to making my home country a better place.”

Cronbach’s alphas were also determined for the selected validity scales. All scales demonstrated high reliability, as displayed in Table 3 (ranging from .772-.946). A series of bivariate correlations between the validity scales (see Table 3), demonstrated the BADD to be a valid measure of distress and dysfunction in this sample, as it was found to be negatively correlated with the two other validity scales measuring well-being. Additionally, the SWLS and PWI were found to be positively correlated with one another as predicted.

Table 3

Reliability and Validity Coefficients for Validity Scales

Validity Scale	# Of Items	Cronbach’s Alpha	Mean (SD)	Correlation BADD	Correlation PWI	Correlation SWLS
BADD	36	.946	76.00 (19.69)	-	-.553*	-.641**
SWLS	5	.889	17.05 (6.21)	-.641**	.540*	-
PWI	8	.772	61.26 (11.46)	-.553 *	-	.540 *

Note: *p < .05; **p < .01

Interscale correlations of the MWA. Most contexts and dimensions on the MWA were significantly correlated with one another ($p < .05$), with the exception of the Physical-Safety Dimension and Collective-National Dimension (see Table 4). The Physical-Safety dimension was significantly correlated with most MWA Contexts and Dimensions with the exception of the Psychological-Transformational dimension, the Collective-Identity, Participatory, and National dimensions, the Transcendent Context, and both the Transcendent-Spirituality and Transcendent-Meaning dimensions. Additionally, The Collective-National dimension was significantly correlated with most MWA contexts and Dimensions with the exception of the Physical Wellness Context, the Physical-Environmental, Health, and Safety dimensions, the Psychological-Emotional and Functional Dimensions, and the Relational-Prosocial dimension.

Scale Validity Analyses

Table 5 presents the validity coefficients for the MWA Contexts and Dimensions.

Significant positive correlations were found between the following MWA contexts and dimensions and the PWI: Psychological Context, Psychological-Emotional, Psychological-Functional, Relational-Relationship Quality, Collective Context, Collective-Identity, and Collective-Community. Due to limitations in sample size, correlations above .33 were also examined, revealing the following contexts and dimensions to be positively correlated with the PWI: Physical Context, Physical-Environmental, Psychological-Transformative, Relational Context, Collective-National, and Transcendent-Meaning.

Table 5

Validity Coefficients for the MWA Contexts and Dimensions

Context and Dimension	BADD	PWI	SWLS
Physical	-.199	.344	-.005
Health	-.240	.254	-.008
Environment	-.025	.361	-.056
Safety	-.293	.243	.047
Psychological	-.694 **	.507 *	.594 **
Emotional	-.759 **	.488 *	.709 **
Functional	-.683 **	.583 **	.666 **
Awareness	-.470 *	.047	.127
Transformative	-.355	.437	.316
Relational	-.533 *	.421	.666 **
Relationship Quality	-.636 **	.565 *	.795 **
Prosocial	-.222	.085	.276
Collective	-.286	.534 *	.346
Identity	-.246	.512 *	.220
Community	-.241	.522 *	.358
Participatory	-.022	-.034	-.013
National	-.321	.447	.486 *
Transcendent	-.019	.204	.095
Meaning	-.452	.408	.521 *
Spirituality	.462 *	-.121	-.415

Note: *p < .05; **p < .01; non-significant correlations above .33 were italicized.

Significant positive correlations were additionally found between the following MWA contexts and dimensions and the SWLS: Psychological Context, Psychological-Emotional, Psychological-Functional, Relational Context, Relational-Relationship Quality, Collective-National, and Transcendent-Meaning. Positive correlations above .33 were also found with the following contexts and dimensions and the SWLS: Collective Context and Collective-Community.

Significant negative correlations were also found between the following MWA contexts and dimensions and the BADD: Psychological Context, Psychological-Emotional, Psychological-Functional, Psychological-Awareness, Relational Context, and Relational-Relationship Quality. Negative correlations below -.33 were also found with the following contexts and dimensions and the BADD: Psychological-Transformative and Transcendent-Meaning. Interestingly, a significant positive correlation was additionally found between the BADD and the Transcendent-Spirituality dimension.

The following four dimensions of the MWA were not found to be either significantly positively or negatively correlated with any validation scale: Physical-Health, Physical-Safety, Relational-Prosocial, and Collective-Participatory. However, the content of the items included on the SWLS do not appear to be measuring the same four dimensions of well-being as measured by the MWA, thereby impacting any potential relationship. It is also possible that the dimensions listed may be correlated with additional measures of well-being used within the larger psychometric study to validate the MWA.

Highest Rated Contexts and Dimensions on the MWA

When comparing mean scores across MWA contexts, it appears that this sample scored highest on the Physical Wellness Context ($M=4.24$), followed by the Relational Wellness Context ($M=3.76$), the Psychological Wellness Context ($M=3.63$), the Collective Wellness Context ($M=3.42$), and finally, the Transcendent Wellness Context ($M=3.13$). Additionally, when asked to rate the five most important areas for determining their well-being, the five highest rated choices included: physical health (69%), daily activities and achievements (68%), relationships with those closest to them (66%), having positive emotions and feelings (55%), and improving their selves and their lives (47%).

Relationships Among Variables

Age and length of time in the U.S. Pearson r correlations were computed to assess bivariate relationships between age, length of time in the U.S. and the MWA contexts and dimensions and validity scales. Table 6 presents the significant Pearson r correlations between age, length of time in the U.S. and the MWA. After applying a pseudo-Bonferroni adjustment to account for experiment-wise error (the significance criteria was set at the more stringent .01 level), age was positively correlated with the following MWA contexts and dimensions: Physical-Environment ($p < .01$), Psychological-Awareness ($p < .01$), Relational-Prosocial ($p < .01$), Collective Context ($p < .01$), Collective-Identity ($p < .01$), Collective-Participatory ($p < .01$), Transcendent Context ($p < .01$), Transcendent-Meaning ($p < .01$), and Transcendent-Spirituality ($p < .01$). Age was also found to be trending towards significance with the following MWA contexts and dimensions: Physical Context ($p < .05$), Physical-Health ($p < .05$), Psychological Context ($p < .05$), Psychological-Functional ($p < .05$), Collective-Community ($p < .05$), and Psychological-Transformative ($p < .05$).

Length of time in the U.S. was also found to be trending towards positive significance with the following MWA contexts and dimensions, which were also positively correlated with age: Psychological-Functional ($p < .05$), Psychological-Transformative ($p < .05$), Collective Context ($p < .05$), Collective-Identity ($p < .05$), and Collective-Participatory ($p < .05$). As was suspected, age and length of time in the U.S. were also found to be significantly correlated with one another ($p < .01$).

Neither age or length of time in the U.S. were significantly correlated with any of the validation scales (BADD, SWLS, PWI), nor were they correlated with the Physical-Safety, Psychological-Emotional, Relational Context, Relational-Relationship Quality, or Collective-National dimensions or contexts on the MWA.

Table 6

Pearson r correlations for age and length of time in U.S.

Context and Dimension	Age	Length of Time in U.S.
Physical	.323 *	
Health	.323 *	
Environment	.325 **	
Psychological	.291 *	
Functional	.285 *	.269 *
Awareness	.382 **	
Transformative	.264 *	.272 *
Relational		
Prosocial	.326 **	
Collective	.389 **	.255 *
Identity	.342 **	.273 *
Community	.311 *	
Participatory	.428 **	.257 *
Transcendent	.413 **	
Meaning	.328 **	
Spirituality	.406 **	

Note: * $p < .05$; ** $p < .01$

Birthplace. To determine if there were differences on any of the MWA contexts and dimensions and participants' place of birth (i.e., born in U.S. versus born in Iran), an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there were statistically significant differences between groups on the following contexts and dimensions of the MWA: Physical-Environmental ($t(59) = -2.82, p < .01$) and Psychological-Awareness ($t(59) = -4.34, p < .001$). A significant difference was also found on the Transcendent Context ($t(59) = -2.95, p < .01$); however, the assumption of homogeneity of variance was not met for this dimension. In all conditions, those born in Iran scored significantly higher on the aforementioned dimensions and items of the MWA.

The following MWA contexts and dimensions were also found to be approaching statistical significance with respect to birthplace: Physical Context ($t(59) = -2.32, p = .02$), Physical-Health ($t(59) = -2.35, p = .02$), Psychological Context ($t(59) = -2.25, p = .03$), Psychological-Transformational ($t(59) = -2.13, p = .04$), Relational-Prosocial ($t(59) = -2.18, p = .03$), Collective-Participatory ($t(59) = -2.19, p = .03$), Transcendent-Meaning ($t(59) = -2.24, p = .03$), and Transcendent-Spiritual ($t(59) = -2.50, p = .02$). In all conditions, those born in Iran scored significantly higher on the aforementioned dimensions and items of the MWA.

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and participants' place of birth. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there were statistically significant differences between groups on the PWI ($t(16) = 3.14, p = .006$), with those born in the U.S. scoring higher

($M = 66.55$, $SD = 9.15$) than those born in Iran ($M = 52.14$, $SD = 52.14$). No statistically significant difference was found between groups on the BADD or SWLS.

Gender. To determine if there were differences on any of the MWA contexts and dimensions and gender, an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance, no statistically significant differences between groups were found on any of the MWA contexts and dimensions.

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and gender. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there was a statistically significant difference between groups on the PWI ($t(17) = -3.04$, $p = .007$), with females ($M = 66.91$, $SD = 9.07$) scoring higher than males ($M = 53.50$, $SD = 10.07$). Differences between groups were also found to be approaching statistical significance on the SWLS ($t(17) = -2.29$, $p = .04$), with females ($M = 23.45$, $SD = 4.52$) also scoring higher than males ($M = 19.50$, $SD = 6.82$). No statistically significant difference was found between groups on the BADD.

Level of education. A one-way between subjects ANOVA was conducted to compare the effect of level of education in, less than college degree (i.e., community college degree or high school degree or equivalent), college/university degree (i.e., B.A., B.S., etc.), and graduate/professional degree (e.g., M.B.A., Ph.D., M.D., etc.), conditions on the MWA contexts and dimensions and the validity scales (BADD, PWI, SWLS). There was a significant effect of level of education on the Transcendent-Spiritual dimension at the $p < .01$ level for the three conditions [$F(2, 59) = 5.13$, $p = 0.009$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those who had obtained a graduate degree ($M = 29.75$, $SD =$

10.12) was significantly different from those who had obtained a college degree ($M = 40.88$, $SD = 11.24$) and from those who had obtained less than a college degree ($M = 40.22$, $SD = 15.96$). These results suggest that high levels of education have an effect on levels of spirituality/religiosity in this sample. Specifically, the results suggest that those who had obtained a graduate/professional degree scored lower on a measure of spirituality than both those who had obtained only a college degree and those who had obtained less than a college degree. However, it should be noted that level of education must be high in order to see an effect in this population.

Income. A one-way between subjects ANOVA was conducted to compare the effect of annual income in those who made less than \$25,000, \$25,000-\$50,000, \$50,000-\$100,000, and over \$100,000, on the MWA contexts and dimensions. There was a significant effect of annual income on the Physical Wellness Context [$F(3, 58) = 4.13$, $p = 0.01$] and the Physical-Environmental dimension [$F(3, 58) = 4.64$, $p = 0.006$] at the $p < .01$ level.

Post hoc comparisons using the Tukey HSD test indicated that the mean score for those with an annual income in the \$25,000-\$50,000 range ($M = 115.13$, $SD = 16.56$) was significantly different than those with an annual income over \$100,000 ($M = 139.22$, $SD = 13.96$) on the Physical Wellness Context and on the Physical-Environmental dimension ($M = 39.63$, $SD = 7.87$; $M = 50.00$, $SD = 5.09$), with those in the higher income range scoring significantly higher. These results suggest that those with an annual income in the \$25,000-\$50,000 range scored significantly lower on dimensions of physical wellness.

Furthermore, the Physical-Safety dimension [$F(3, 58) = 3.64$, $p = 0.018$] and Collective-Identity dimension [$F(3, 58) = 2.83$, $p = 0.047$] were also found to be approaching statistical significance. On the Physical-Safety dimension those with an annual income in the \$25,000-

\$50,000 range ($M = 32.25$, $SD = 4.17$) was also significantly different than those with an annual income over \$100,000 ($M = 39.11$, $SD = 5.00$), those with an annual income less than \$25,000 ($M = 39.50$; $SD = 6.19$), and those with an annual income in the \$50,000-\$100,000 range ($M = 39.63$, $SD = 6.44$). However, no statistically significant difference was found between mean scores on the Collective-Identity dimension.

A one-way between subjects ANOVA was conducted to compare the effect of annual income in those who made less than \$25,000, \$25,000-\$50,000, \$50,000-\$100,000, and over \$100,000, on the BADD, PWI, and SWLS. Annual income was found to be approaching statistical significance on the PWI [$F(3, 15) = 3.79$, $p = 0.03$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those with an annual income in the \$25,000-\$50,000 range ($M = 45.33$, $SD = 5.03$) was significantly different than those with an annual income over \$100,000 ($M = 67.67$, $SD = 17.90$), with those in the higher income range scoring significantly higher.

A one-way between subjects ANOVA was additionally conducted to compare the effect of financial status for the categories of, “My basic needs are met (food, shelter, clothing) but no extras,” “I have everything I need and a few extras,” “I am able to purchase many of the things I want,” and “Within limits, I am able to have luxury items like international vacations, new cars, etc. or I can buy nearly anything I want, anytime I want,” on the MWA contexts and dimensions and validity scales. There was a significant effect of financial status on the Physical-Safety dimension [$F(3, 58) = 3.95$, $p = 0.01$], at the $p < .01$ level. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those who had everything they needed and a few extras was significantly different than those who endorsed either being able to have luxury items like international vacations, new cars, etc., within limits, or being able to buy nearly anything

they wanted, anytime they wanted. Specifically, those in the higher financial category scored higher in the area of safety ($M = 42.41$, $SD = 4.64$) versus those in the lower financial category ($M = 36.11$, $SD = 6.36$). No significant differences were found between the other categories.

Furthermore, the Physical Wellness Context [$F(3, 58) = 2.76$, $p = 0.05$] and Physical-Environmental dimension [$F(3, 58) = 3.104$, $p = 0.03$] were also found to be approaching statistical significance. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those who had everything they needed and a few extras was significantly different than those who endorsed either being able to have luxury items like international vacations, new cars, etc., within limits, or being able to buy nearly anything they wanted, anytime they wanted. Those in the higher financial category scored higher in the areas of overall physical wellness ($M = 141.24$, $SD = 13.92$) and environment ($M = 49.82$, $SD = 5.50$) versus those in the lower financial category ($M = 124.89$, $SD = 17.23$; $M = 42.84$, $SD = 7.07$ on both categories respectively).

Student status. To determine if there were differences on any of the MWA contexts and dimensions and participants' current student status (i.e., both part-time and full-time students versus non-students), an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, differences between groups were found to be approaching statistical significance on the Relational-Prosocial dimension of the MWA ($t(60) = 1.96$, $p = .05$), with those who were currently students ($M=44.93$, $SD=8.03$) scoring higher than those who were currently not students ($M=41.36$, $SD=6.32$).

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and current student status. No statistically significant difference was found between groups on the BADD, PWI, or SWLS.

Marital and relationship status. To determine if there were differences on any of the MWA contexts and dimensions and participants' marital status (i.e., currently married versus currently not married), an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there were statistically significant differences between groups on the following contexts and dimensions of the MWA: Physical Context ($t(60) = -2.79, p < .01$), Physical-Environmental ($t(60) = -3.28, p < .01$), Physical-Health ($t(60) = -2.60, p = .01$), Collective Context ($t(60) = -2.64, p = .01$), Collective-Community ($t(60) = -2.66, p = .01$), Transcendent Context ($t(60) = -2.85, p < .001$), and Transcendent-Spiritual ($t(60) = -3.31, p < .01$). Those who were currently married scored higher on all contexts and dimensions listed, with the exception of the Physical Wellness Context, for which those who were not currently married scored higher. The Collective-Identity dimension ($t(60) = -2.83, p = .02$) was also found to be approaching statistical difference between groups, as those who were not currently married scored higher.

T-tests were also conducted to determine if there were differences on any of the MWA contexts and dimensions and those who were currently single and had never been married versus those who were not (e.g., currently in a relationship, divorced, or separated). After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there were statistically significant differences between groups on the following contexts and dimensions of the MWA: Collective Context ($t(60) = 2.63, p =$

.01), Collective-Identity ($t(60) = 2.58, p = .01$), Transcendent Context ($t(60) = 3.43, p = .001$), and Transcendent-Spiritual ($t(60) = 3.67, p = .001$). Those who were single and had never been married scored lower on all contexts and dimensions listed as compared to those who were not (e.g., currently in a relationship, divorced, or separated). Furthermore, it appears that those who were not currently married, but were also not single (i.e., those who were currently living together with their life partner or those who were divorced) scored higher on the dimension of Collective-Identity ($t(60) = -2.83, p = .02$; $t(60) = 2.58, p = .01$).

Differences between those who were currently single and had never been married versus those who were not, were also found to be approaching statistical significance on the following MWA contexts and dimensions: Physical-Environmental ($t(60) = 2.24, p = .03$), Physical-Health ($t(60) = 2.41, p = .02$), Psychological Context ($t(60) = 2.08, p = .04$), Psychological-Transformational ($t(60) = 2.02, p = .05$), Collective-Community ($t(60) = 2.17, p = .03$), and Transcendent-Meaning ($t(60) = 2.23, p = .03$). Those who were single and had never been married scored lower on all contexts and dimensions listed as compared to those who were not.

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and marital status. No statistically significant difference was found between groups on the BADD, PWI, or SWLS.

A one-way between subjects ANOVA was additionally conducted to compare the effect of relationship status between those who were not currently dating or going out with anyone ($n=13$), those who were dating or going out with someone but not in a relationship ($n=20$), those who were in an intimate relationship with a boyfriend/girlfriend ($n=6$), and those who were in a permanent relationship with their life partner ($n=23$), on the MWA contexts and dimensions and the validity scales. After a pseudo-Bonferroni adjustment was made, relationship status was

found to be approaching statistical significance on the Physical Wellness Context [$F(3, 58) = 3.34, p = 0.03$], Physical-Environmental dimension [$F(3, 58) = 3.47, p = 0.02$], Physical-Health dimension [$F(3, 58) = 3.59, p = 0.02$], Psychological-Transformational dimension [$F(3, 58) = 3.07, p = 0.04$], and Transcendent-Spirituality dimension [$F(3, 58) = 3.03, p = 0.04$] at the $p < .05$ level for the four conditions.

Post-hoc comparisons using the Tukey HSD test indicated that the mean score for those who were in a permanent relationship with their life partner ($M = 138.43, SD = 13.91$) was significantly different than those who were dating or going out with someone but not in a relationship ($M = 122.50, SD = 19.07$) for the Physical Wellness Context. However, those who were not currently dating or going out with anyone and those who were in an intimate relationship with a boyfriend/girlfriend did not significantly differ on this context. The mean score for those who were in a permanent relationship with their life partner ($M = 49.17, SD = 6.11$) was also significantly different than those who were dating or going out with someone but not in a relationship ($M = 42.65, SD = 7.85$) for the Physical-Environmental dimension in addition to the Physical-Health dimension ($M = 50.00, SD = 6.22$; $M = 43.60, SD = 8.15$). Those who were not currently dating or going out with anyone and those who were in an intimate relationship with a boyfriend/girlfriend also did not significantly differ on these dimensions. On the Psychological-Transformational dimension, the mean score for those who were in a permanent relationship with their life partner ($M = 43.91, SD = 6.48$) was also significantly different than those who were not currently dating or going out with anyone ($M = 36.15, SD = 6.89$). Additionally, although a significant difference was found on the Transcendent-Spirituality dimension, post-hoc analyses revealed no true difference between groups on this dimension. Taken together, these results suggest that being in a permanent

relationship with a life partner has an effect on physical wellness (including environment and health) and psychological transformation. However, these results must be interpreted with caution as they were only found to be approaching statistical significance due to limitations in samples size.

Child caregivers. To determine if those who were currently caregivers for children under the age of 18 versus those who were not currently child caregivers, scored differently on any of the MWA contexts and dimensions, an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance and a pseudo-Bonferroni adjustment was made, there were statistically significant differences between groups on the Psychological-Awareness dimension of the MWA ($t(60) = 2.53, p = .01$). A significant difference was also found on the Collective-Identity dimension ($t(60) = 3.05, p = .01$); however, the variance was not homogeneous on this item. In both conditions, those who were currently caregivers of children scored higher on well-being.

Differences between groups were also found to be approaching statistical significance on the following MWA contexts and dimensions: Psychological-Transformational ($t(60) = 2.13, p = .04$), Transcendent Context ($t(60) = 2.23, p = .03$), and Transcendent-Spiritual ($t(60) = 2.41, p = .02$), with those who were currently caregivers of children scoring higher.

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and child caregiver status. No statistically significant difference was found between groups on the BADD, PWI, or SWLS.

Elderly caregivers. To determine if there were differences on any of the MWA contexts and dimensions and those who were currently caregivers of an elderly individual versus those who were not, an independent sample t-test was conducted. After the equalities of variance were

confirmed by Levene's Test for Homogeneity of Variance, no statistically significant differences between groups were found on any of the MWA contexts and dimensions.

An additional independent sample t-test was conducted to determine if there were differences on any of the validation scales (BADD, PWI, SWLS) and elderly caregiver status. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance, differences between groups on the SWLS were found to be approaching statistical significance ($t(17) = -2.25, p = .04$), with those who were elderly caregivers scoring lower ($M = 14.50, SD = 4.95$) than those who were not ($M = 23.94, SD = 5.65$). No statistically significant difference was found between groups on the BADD or PWI.

Religion, work status, illness status, and stress. To determine if there were differences on any of the MWA contexts and dimensions or on any of the validation scales (BADD, PWI, SWLS) and religion (i.e., Jewish or Muslim) or those who were currently being impacted by an illness or health condition versus those who were not, an independent sample t-test was conducted. After the equalities of variance were confirmed by Levene's Test for Homogeneity of Variance, no statistically significant differences between either groups was found on any of the MWA contexts and dimensions or the BADD, PWI, or SWLS.

A one-way between subjects ANOVA was conducted to compare the effect of those who were currently working full-time, those who were currently working part-time, and those who were not currently working by choice, and those who were experiencing: less stress than usual over the past two weeks, about the same stress as usual over the past two weeks, or more stress than usual over the past two weeks on the MWA contexts and dimensions and the validity scales. No statistically significant differences between groups were found on any of the MWA contexts and dimensions or on any of the validity scales.

Chapter V. Discussion

This study focused on examining the validity of a comprehensive and culturally-inclusive measure of well-being, the MWA, developed in response to a lack of such measures, in an Iranian sample. The study also sought to examine the relationship of several demographic variables to differing contexts and dimensions of well-being as delineated by the MWA. Although there have been several conceptualizations of mental health beliefs and practices in the Iranian population, no studies have specifically examined factors predicting well-being in this population with a culturally validated assessment measure. Furthermore, there is a lack of assessment measures that pay particular attention to collectivistic values (noted to be important within the Iranian population) in survey development or validation; this study sought to fill in that gap.

Reliability and Validity of the MWA

Reliability and validity analysis of the MWA in an Iranian sample revealed the scale as a reliable measure of well-being for this population overall, as Cronbach's alpha ranged from .581 - .936 across all contexts and dimensions. All five Wellness Contexts and most (i.e., 12 out of 15) dimensions demonstrated good to excellent reliability (ranging from .873-.936), with the exception of the three dimensions of Psychological-Awareness, Collective-Participatory, and Collective-National (ranging from .581-.694), which demonstrated poor to acceptable reliability.

Reliability analysis conducted in the present study was found to be largely similar to the preliminary analysis conducted as part of the larger psychometric study validating the MWA (Harrell et al., 2013). Most contexts and dimensions showed similar reliability (ranging from .70 - .96), as dimensions showing weaker reliability in the larger sample were similar to dimensions showing weaker reliability in the Iranian sample. Specifically, the Collective-National

dimension demonstrated the lowest reliability in the present sample (.58) and in the larger sample (.70). The Psychological-Awareness dimension also demonstrated lower reliability levels in the larger sample (.75), similar to the present sample (.61). However, it should be noted, that all contexts and dimensions were still found to demonstrate good to excellent reliability in the larger sample. This may be due to limitations in sample size in the present study. Nonetheless, the Collective-National and Psychological-Awareness dimensions, should be monitored in future studies with larger sample sizes to determine if reliability levels increase or if items listed in these dimensions can either be dropped or incorporated into other dimensions showing high interscale correlations.

Removing specific items with lower item-total correlations from the three dimensions that did not show adequate reliability, significantly improved alpha levels. When removing item 93 (“I stopped to pay attention to what I was feeling emotionally and/or physically”) on the MWA from the Psychological-Awareness dimension, the alpha increased from .611 to .664. Removing item 126 (“I felt committed to making my home country a better place”) on the MWA from the Collective-National dimension, improved the alpha from poor to acceptable (.581 to .601). Finally, removing item 6 (“I did something to help make the world a better place”) on the MWA from the Collective-Participatory dimension slightly improved the alpha level (.694 to .701). Due to limitations in sample size and the preliminary nature of this study, however, results of reliability coefficients must be interpreted with caution as alpha levels may increase as the sample size grows larger. Nevertheless, it will be important to continue to monitor the items mentioned in future studies conducted with Iranians in a larger sample.

It is also hypothesized that the low alpha levels on the Collective-National dimension may be unique to this sample, as all participants were either first or second generation

immigrants. All items in this dimension refer to the participant's "home country" in item content (e.g., "My home country was strong and stable in terms of leadership and political matters."). This may prove to be particularly confusing for immigrant groups struggling with their identity and understanding of the term "home country." Indeed, responses toward describing racial-ethnic identification varied greatly, with some choosing to include the word "American" in their responses, while others did not. This result proves to be similar to previous studies examining ethnic identity in Iranian immigrants (e.g., Mahdi, 1998). Thus, examining factors contributing to ethnic self-identification will be important to investigate further in future studies, as they may have potential implications for the wording of the items in this dimension.

Most contexts and dimensions on the MWA were additionally found to be significantly correlated with one another, thereby supporting the hypothesis that the dimensions on the MWA are correlated factors associated with well-being. Despite this finding, however, the Physical-Safety Dimension and Collective-National Dimension were not found to be significantly correlated with several other dimensions on the MWA, suggesting that these dimensions may be distinct measures of wellness for this sample. The Physical-Safety dimension was not found to be significantly correlated with the Psychological-Transformational dimension, the Collective-Identity, Participatory, and National dimensions, the Transcendent Context, and both the Transcendent-Spirituality and Transcendent-Meaning dimensions. Additionally, The Collective-National dimension was not found to be significantly correlated with the Physical Wellness Context, the Physical-Environmental, Health, and Safety dimensions, the Psychological-Emotional and Functional Dimensions, and the Relational-Prosocial dimension.

With regards to validity, most MWA contexts and dimensions were found to be either positively correlated with alternate measures of well-being (PWI or SWLS) or negatively

correlated with a measure of distress and dysfunction (BADD), as hypothesized. However, four dimensions of the MWA were not found to be either positively or negatively correlated with any validation scale (i.e., Physical-Health, Physical-Safety, Relational-Prosocial, and Collective-Participatory dimensions). One possible explanation for this finding is that the items on the SWLS do not appear to be specifically measuring dimensions of health, safety, prosocial relations, or participation in community activities directly. Instead the SWLS appears to broadly assess how satisfied an individual is with their life as a whole, allowing individuals to weigh different life domains in any way they chose (Pavot & Diener, 1993). For those who do not factor the dimensions listed into their perception of overall life satisfaction, their scores would not be representative of these life domains. Therefore, it is suspected that for the participants who completed the validity scales, these dimensions may not have related to their perception of how satisfied they were with their life as a whole. Alternatively, for those who rated health, safety, prosocial relations, or participation in community activities as important to their well-being and life satisfaction, it is hypothesized that there would be high correlations with this scale. Limitations in sample size impact the interpretation of this finding.

Additionally, preliminary results from the larger MWA psychometric study revealed that the MWA was not correlated to the SWLS on the Relational-Prosocial dimension, Collective Wellness Context, Collective-Identity and Participatory dimensions, Transcendent Wellness Context, and Transcendent-Spirituality dimension (Harrell et al., 2013). However, these contexts and dimensions were still found to be either positively or negatively correlated with the Flourishing Scale or the Scale of Positive and Negative Emotions. Therefore, the Collective-Identity and Relational-Prosocial dimensions should also continue to be monitored in future studies.

Interestingly, a significant positive correlation was additionally found between the BADD and the Transcendent-Spirituality dimension, suggesting that those who scored higher on this dimension also scored higher on a measure of distress and dysfunction. Although not significant, this dimension also displayed a negative trending correlation with the SWLS and PWI. These results are also dissimilar to what was found in the larger MWA psychometric study, as the Transcendent-Spirituality dimension was found to be negatively correlated with the Negative Emotions subscale on the SPANE and positively correlated with the Flourishing Scale (Harrell et al., 2013). This finding suggests that, among Iranians who participated in this study, those who scored higher on a dimension of spirituality or religiosity, also scored higher on a scale measuring distress and dysfunction and seem to display a negative trend towards overall life satisfaction.

This finding appears to be contrary to studies reporting that older Iranians seem to believe that mental health is synonymous with spiritual health (Martin, 2009). However, in Martin's (2009) study participants consisted of older Iranian immigrants who were newer to the U.S. (average length of time in the U.S. was 13.5 years) and spoke limited English, whereas, in the present study, older Iranian participants had been in the U.S. for longer periods of time (average length of time in the U.S. was 26 years). This finding may suggest that whatever mental health benefits newer Iranian immigrants obtain from spirituality, appear to decline with their length of time living in the U.S. This is also consistent with the finding that Iranians who immigrated at an earlier age were more likely already exposed to western ideals (Jalali, 1996), making them more assimilated to overall mainstream U.S. culture.

Lun and Bond (2013) found that in societies where religious socialization was less supported, individuals may be more likely to engage in spiritual practice for the sake of meeting

material needs or coping with significant life challenges, which can contribute to the negative association between spiritual practice and well-being. This finding is also moderated by items used to measure spirituality. Indeed, on the Transcendent-Spirituality dimension of the MWA, item content is largely related to spiritual practices or behaviors (e.g., “I received valuable counsel from a minister, rabbi, imam, priest, guru, pastor, or other religious leader.”). Therefore, it is possible that individuals who scored high on this dimension had turned to religion as a means of coping with distress and dysfunction, thereby impacting the strong correlation between this dimension and the BADD.

An alternate explanation for this finding may be related to levels of discrimination perceived by religious Iranian immigrants. As most Iranians identify as Muslim (U.S. Department of State, 2012), and the majority of the participants in this study included those identifying as either Muslim or Jewish, it is hypothesized that these groups may feel increasing levels of discrimination and marginalization in the United States due to their religious affiliation (Ahmed, 2010; Heinemann et al. 2007), which may impact overall levels of life satisfaction and levels of distress and dysfunction (Werkuyten & Nekuee, 1999).

Rating and Importance of MWA Contexts

Iranians included in this study rated physical health, daily activities and achievements, relationships with those closest to them, having positive emotions and feelings, and self-improvement as the five highest rated contributors to their overall well-being and life satisfaction. This finding is largely similar to reports from previous studies, which found that mental health is perceived in relation to good relationships and general health and that mental health is considered, a coordination between a person’s mind, emotion, and behavior (Jafari et al., 2010). It is possible that the high levels of educational and occupational achievement

prevalent amongst Iranian immigrants to the U.S. (Bozorgmehr & Douglas, 2011), is correlated to the level of importance Iranians place on their daily activities and achievements and self-improvement towards their overall well-being. Indeed, this study similarly found that most participants were highly educated and had obtained high-skill professional or business occupations.

When compared to preliminary results of the larger MWA psychometric study, Iranians in this sample scored similarly on the five highest rated dimensions of overall well-being (Harrell et al., 2013). One exception was found, however, as those who participated in the larger psychometric study did not rate self-improvement as their top rated dimension, but instead rated finding meaning and purpose as important. This suggests that when compared to other racial-ethnic groups, Iranians in general may believe that participating in acts of self-improvement may take precedence over finding meaning or purpose, when thinking about their overall well-being and life satisfaction. This finding may relate to the high rates of educational and occupational attainment amongst Iranian immigrants (Bozorgmehr & Douglas, 2011).

In terms of actual scores, Iranians who participated in this study scored highest on the Physical Wellness Context, followed by the Relational Wellness Context, the Psychological Wellness Context, the Collective Wellness Context, and finally, the Transcendent Wellness Context. These scores seem to correlate with the dimensions participants rated as most important to well-being, as all noted dimensions relate to the top three contexts with the highest scores on the MWA (Physical, Relational, and Psychological).

Demographic Variables Contributing to Well-Being in Iranians

Age. Age was found to show a strong positive correlation with the Physical-Environment dimension, the Psychological-Awareness dimension, the Relational-Prosocial dimension, the

Collective Context, Collective-Identity and Collective-Participatory dimensions, the Transcendent Context, and the Transcendent-Meaning and Transcendent-Spirituality dimensions on the MWA. These results suggest that as Iranians age, they seem to portray higher levels of being in positive environments, having a stronger sense of physical and emotional awareness, displaying prosocial behavior, having higher levels of sociocultural identity and community participation, and having a higher sense of both meaning and purpose and religiosity/spirituality.

Studies conducted on life-span and overall well-being have shown that age accounts for very little of the variance in life satisfaction, and pleasant affect appears to decrease with age in Western nations (Diener & Suh, 1998). However, in collectivistic nations, it appears that age does not have a negative relationship with life satisfaction, but is also moderated by health (Diener & Suh, 1998). Therefore, for those who identify with collectivism (i.e., Iranians) but have immigrated to a more Western nation that has better access to health care (i.e., United States), it is possible that life satisfaction and well-being may increase with age, similar to what was found in the present study. For Iranian immigrants in this study, well-being appeared to increase with age on several dimensions, implying that age may serve as a protective factor towards well-being in those identifying with collectivistic cultures, while living in more individualistic, Western nations.

Although, this finding may additionally be impacted by the strong positive correlation found between participants' age and length of time in the U.S., which suggests that older participants have, on average, had more time in the U.S. and, thereby, more time to acculturate or assimilate to western beliefs or ideals. As resettling in a foreign country is a source of stress for many immigrants (Nerad & Janczur, 2000), it is hypothesized that the extra time older individuals in this sample have had to become accustomed to U.S. norms may have added

additional health benefits. Moreover, older participants in this study were more likely to have immigrated to the U.S. before the 1979 Revolution, providing them additional immunity against stress related to political or religious refugee status, in addition to most likely being predisposed to western ideals prior to immigration (Jalali, 1996). An additional confounding factor related to this interpretation may be impacted by the younger average age of this sample (i.e., average age was 37); therefore, it is possible that this finding may change in future studies with a larger sample size and a greater age dispersion.

Length of time in the U.S. Length of time in the U.S. was only found to be approaching significance with the Psychological-Functional dimension, Psychological-Transformative dimension, the Collective Context, and Collective-Identity and Collective-Participatory dimensions on the MWA, which were also positively correlated with age. These results suggests that, as their time in the U.S. increases, Iranians appear to achieve greater levels of being productive in a functional-behavioral capacity, being able to make self-improvements, and having higher levels of overall collective wellness, including sociocultural identity and community participation. However, these results must be interpreted with caution due to limitations in sample size, as these correlations are only approaching statistical significance in this sample. Assuming that length of time in the U.S. is correlated to higher rates of acculturation, it is possible that this finding may be related to increased rates of acculturation. This is consistent with the finding that acculturation has been associated negatively with negative mental health (i.e., depression, anxiety, psychological distress, and negative affect) and positively with positive mental health (i.e., self-esteem, satisfaction with life, and positive affect; Yoon et al., 2013). Similarly, Ghaffarian (1998) found that maintaining a bicultural identity produced the least amount of mental disturbances and the highest amount of mental health in

Iranian immigrants, relating to the higher rates of both collective and psychological wellness for this group. Future studies should incorporate a measure of acculturation to further deepen our understanding of this finding.

Birthplace. Being born in Iran appeared to provide higher satisfaction in terms of being in a positive physical environment, higher levels of psychological, emotional, and physical awareness, and greater levels of spirituality and meaning and purpose. This is interesting, given that 86% of participants who were born in Iran were either third or fourth wave immigrants and, therefore, hypothesized to be more susceptible to developing psychological symptoms (Jalali, 1996). Additionally, those born in Iran scored lower on the PWI, when compared to those born in the United States. This finding suggests that when Iranians born in Iran are asked to rate their well-being subjectively (PWI) based on how satisfied they feel on different life dimensions, they score lower than when asked about specific behaviors they have engaged in over the past two weeks (MWA). This further points to the gap that needed to be filled within current measurements of well-being, as immigrants may have higher rates of well-being than was originally suspected, especially with regard to areas measuring transformation, life improvement, and spirituality.

Several studies conducted with Latino immigrants and their descendants suggest that the erosion of protective features from their culture of origin contributes to an increase in risky behaviors and overall well-being across generations (Barrera, Gonzales, Lopez, & Fernandez, 2004; Mogro-Wilson, 2008). Similar to Iranian families, parenting practices and relationships among Latino families are organized by values highlighting the centrality of family integrity (i.e., *familismo*; Germán, Gonzales, & Dumka, 2009). However, in Latino families it appears that *familismo* decreases across generations as Latinos acculturate, and this decline appears

related to an increase in externalizing behaviors and negative health outcomes (Gil, Wagner, & Vega, 2000). The advantaged health status of first-generation Latinos has come to be known as the “immigrant paradox” (Markides & Coreil, 1986, p. 255; Vega & Sribney, 2011, p. 152). Due to the higher scores on several dimensions of well-being found in the participants who were born in Iran in the present study, it is hypothesized that Iranian immigrants may also show evidence of this “immigrant paradox.” Future, cross-generational studies with Iranians are needed in order to replicate this finding.

Marital and relationship status. Those who were currently married scored higher on dimensions of physical environment and health, overall collective wellness, including community connectedness, and overall transcendent wellness, including spirituality. Additionally, those who were single and had never been married scored lower on aspects of overall collective wellness, including a sense of identity and overall transcendent wellness, including religiosity/spirituality, suggesting that those who were either currently married or living with their life partner scored higher on these dimensions. Furthermore, in terms of overall physical wellness, including environment and health, those who were in a permanent relationship with their life partner seemed to fare better than those who were casually dating. Lastly, being in a permanent relationship was approaching a significant correlation to higher rates of life transformation, when compared to those who were not currently dating anyone. Taken together, these results suggest that being in a permanent relationship has an effect on overall physical wellness (including environment and health), overall collective wellness, including community connectedness, and overall transcendent wellness, including spirituality for this sample. These results support the finding that married people report being happier regardless of level of individualism within the nation where they reside (Diener et al., 1999).

Level of education and student status. Those who had obtained a graduate/professional degree scored lower on a measure of spirituality than both those who had obtained only a college degree and those who had obtained less than a college degree. These results suggest that high levels of education have an effect on levels of spirituality/religiosity in this sample. This finding is similar to international studies reporting that less education is correlated to higher rates of spirituality and faith (WHOQOL SRPB Group, 2006).

Additionally, those who were currently students displayed higher rates of prosocial behavior (i.e., giving advice, helping someone, showing patience) than those who were currently not students. This may potentially be attributed to those who are currently students having more opportunities to engage in such behaviors; however, this result must be interpreted with caution as this finding was only found to be approaching significance in this sample.

Income. Those with an annual income over \$100,000 scored higher than those with an annual income in the \$25,000-\$50,000 range on overall physical wellness and environmental conditions. Additionally, those who endorsed either being able to have luxury items like international vacations, new cars, etc., within limits, or being able to buy nearly anything they wanted, anytime they wanted scored higher than those who had everything they needed and a few extras in the area of physical safety.

These results suggest that those with higher income and financial standing have higher levels of overall physical wellness (both environment and safety) and subjective perceptions on quality of life. These findings are similar to what was proposed in Veenhoven's (1995) *Livability Theory*, in which he predicted that income only affects subjective well-being as it allows individuals to meet their basic needs (i.e., food, shelter, clothing). Additionally, national studies have also found that income does not strongly predict subjective well-being (Diener et al,

1999), proving that beyond environmental and living conditions, income does not seem to predict other factors of well-being for this population.

Child and elderly caregivers. Those who were currently caregivers of children scored higher on dimensions of psychological, emotional and physical awareness and cultural identity. This is consistent with the finding that the importance of family is noted to be central factor in the mental health outcomes of Iranians and may lead to higher rates of well-being on these dimensions (Hojat et al., 2000; Jafari et al., 2010; Jodeyr, 2003; Mostofi, 2003; Shahmirzadi, 1983; Shamloo, 2010).

However, those who were elderly caregivers scored lower on a measure of overall life satisfaction, when compared to those who were not, although this finding was only found to be approaching statistical significance. These results may indicate that having children in this population may correlate to positive mental health outcomes, while being a caregiver for an elderly individual may not provide the same mental health effects, although a larger sample size is needed in order to replicate this finding. This finding is consistent with meta-analyses conducted on elderly caregiver status and its correlation to higher rates of stress and depression and lower levels of subjective well-being, physical health, and self-efficacy than non-caregivers (Pinquart & Sörensen, 2003).

Gender, religion, work status, illness, and stress. The remaining demographic factors of religion, work status, illness, and stress levels did not appear to impact any dimension of well-being. Additionally, although there were no significant gender differences on any context or dimension on the MWA, differences on the PWI were found on gender for this measure. Specifically, it was found that females scored higher on this scale. This finding is similar to other studies that have found that females usually report higher subjective well-being,

but the differences often disappear when other demographic variables are controlled (Diener et al., 1999).

Methodological Limitations

The present study was limited by potential threats to internal and external validity. Threats to internal validity were possible as a result of participant characteristics and data collection procedures and threats to external validity were possible as a result of limitations in sample size.

Participants comprised a voluntary, non-random, convenience, and non-clinical sample from Iranian groups and organizations. Only those who volunteered to participate in this study were included in the sample, implying that subjects may have been cooperative to the research, psychologically curious, and/or eager to participate in the prize drawing. An additional limitation of the study is volunteer sample bias, as those who are members of Iranian groups and organizations may be more connected to their culture than those who are not. Lastly, most participants included in this study resided in Southern California, which places additional limitations on the generalizability of results. It is possible that people of Iranian descent residing in different regions of the U.S., most of which consist of smaller concentrations of Iranians, may understand and experience well-being in different ways. Future studies should seek to include participants from a wider representation of regions in order to assess potential geographic differences.

Data collection procedures might also have posed some threat to internal validity. The set of questionnaires administered were based on self-report, and taken on-line, which was not provided under the researcher's control. For example, even though participants were instructed to answer the items by themselves, it remained unclear if these instructions were followed. It is

possible that some questionnaire responses could have been discussed with friends or filled in by somebody other than the participant. Lastly, limitations in sample size largely limited generalizability of the results of this study and impacted the interpretation of results. Moreover, because this study was correlational in nature, it is important not to imply causality of the factors found to be related to well-being, as other factors may be confounding any potential relationships found.

Potential Contributions of the Present Study

"Because resettling in a foreign country is a significant source of stress, immigrants are at risk of developing more mental health disorders than members of the host country" (Nerad & Janczur, 2000, p. 2). However, some immigrants fare better than others, making it important to understand more about positive well-being. Although there has been a major increase in the number of Middle Eastern immigrants and their descendants living in the United States, few efforts have been made to study the unique challenges this population faces. Given the lack of psychological research on Iranian populations, despite its limitations, this study was able to provide preliminary psychometric data on the Multidimensional Well-Being Assessment and potentially contribute to a greater understanding of the mental health of people of Iranian descent living in the United States. This study has implications for mental health professionals who work with individuals of Iranian descent as well as other culturally or ethnically diverse populations. It is imperative to maximize the cultural relevance of care and the cultural competence of health and social service professionals across a broad spectrum of races and ethnicities. This study aimed to enhance the understanding of well-being in Iranian populations, with the hopes of being able to inform clinicians in developing culturally syntonic therapeutic interventions in their work with those of Iranian descent.

This study found that, in terms of their highest rated dimensions contributing to overall well-being and life satisfaction, Iranians rate their physical health, daily activities and achievements, relationships with those closest to them, having positive emotions and feelings, and self-improvement as most important. Overall, Iranians who were older and had resided in the U.S. longer, had higher incomes, were married, and had children, seemed to rate themselves higher on several dimensions of well-being. This finding was consistent with the literature in that Iranians have been found to emphasize the importance and centrality of family to their overall well-being. As age and length of time in the U.S. were found to be correlated with one another it may be that older Iranians have become more accustomed to Western ideals and norms, while maintaining aspects of culture and community connectedness that have provided extra mental health benefits. More research is needed in this area to determine the causality of these relationships.

An additional goal of this study was to contribute to the psychological literature by examining the validity and reliability of a multicultural well-being assessment measure, as well-being plays a significant role in both physical and psychological health. This measure hopes to shed light onto factors of well-being that may not have been previously considered, with particular regard to collectivistic values. More specifically, the preliminary results found in this study have been able to expand current conceptualizations of well-being and mental health for those of Iranian descent. Although additional research on the validity of this scale must be conducted, it appears that the MWA shows promising results with regards to reliability and validity in the Iranian population. It is hopeful that future studies conducted with the MWA can both expand and deepen our understanding of what brings individuals from all backgrounds and cultures happiness, satisfaction, and wellness.

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APPENDIX A

Text for Email, Postal, Mail or Telephone Recruitment of Cooperating Organizations

Text for email, postal, mail or telephone recruitment of cooperating organizations

Hello/Dear [Dr./Ms./Mr. insert name],

My name is [insert your name here] and I am a research assistant for Dr. Shelly Harrell at Pepperdine University. Dr. Harrell does research on Well-Being and Diversity. She is developing an instrument called the Multidimensional Well-Being Assessment and the main purpose of our research is to better understand and measure well-being for different people in different life situations.

On behalf of Dr. Harrell, I would like to ask for your help recruiting people for our study by allowing us to announce the research project at a meeting, distribute flyers, or collect data from people affiliated with your organization. We will appreciate any level of assistance that you can provide.

Data collection involves completion of various sets of questionnaires that take between 40 minutes to an hour to complete. People can participate by completing our questionnaires online, as well as individually or in a group administration. People will be informed that all participation is completely voluntary. Those who do complete our questionnaire will be eligible to enter our weekly prize drawing for a chance to win a \$30 Gift Certificate to their choice of over 100 retail stores and restaurants. Participants will be given the research website address to attain results of the study if so desired.

Our "Information for Research Participants" document and a copy of our questionnaire is attached/enclosed for your review, along with an Agreement Form (IF PHONE: "We would be glad to send you additional documents for your review."). We would also be glad to arrange a telephone call to address any questions you might have. **We can be contacted at team@wellbeingresearch.net or at 424-442-0053.**

If you agree to allow us to announce our research or collect questionnaires at [name of site], please complete the agreement form and send it back to us by fax, as an email attachment, or by postal mail. Alternatively, if you are in the Los Angeles area, one of our staff may be able to pick up the permission form from your office.

FAX- 888-385-7845

EMAIL- team@wellbeingresearch.net

MAILING ADDRESS:

The Well-Being Project
c/o Dr. Shelly Harrell
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive, 5th floor
Los Angeles, CA 90045

Thank you so much for your consideration!

Sincerely,

[Insert your name here]

APPENDIX B

Screenshots of Online Questionnaire

INTRODUCTION AND CONSENT TO PARTICIPATE

How have YOU been doing lately?

Online Questionnaires!
Win Gift Certificate Prizes!
Contribute to Research!

THE WELL-BEING PROJECT is a research study being conducted by Dr. Shelly Harrell and the Harrell Research Group at Pepperdine University's Graduate School of Education and Psychology. We want to better understand and measure well-being for different people in different life situations. We are trying to get a large diversity of people to complete our questionnaire and help us learn more about what makes life GOOD!



For more info visit us at www.wellbeingresearch.net or email wellbeing@harrellresearchgroup.org



**Thank You for Taking The Time to Contribute
 Your Perspective and Experience to our
 Well-Being Project!**

*-Dr. Shelly Harrell and The Harrell Research Group
 Pepperdine University Graduate School of Education and Psychology*

PLEASE READ THE INFORMATION BELOW.

You can then indicate whether you wish to continue or decline participation in this research project.

INFORMATION FOR RESEARCH PARTICIPANTS

Harrell Research Group (HRG) Well-Being Project: Adult Online Study

DESCRIPTION: The "HRG Well-Being Project: Adult Online Study" is a research study being conducted by Shelly P. Harrell, Ph.D. and The Harrell Research Group at Pepperdine University's Graduate School of Education and Psychology. This study is part of a group of research projects designed to gain a more inclusive and comprehensive understanding of well-being among a diversity of adults (18 years or older).

ONLINE QUESTIONNAIRE COMPLETION: Participation in this research involves completing a set of online questionnaires about your recent feelings and experiences, both positive and negative. Completion of the questionnaires will take between approximately 40-60 minutes depending on whether you choose to complete only the Main Questionnaire or participate in the Full Study.

DOWNLOAD OPTION: Participants may also choose to download and print a physical copy of the questionnaire from the website and participate in the "Adult Questionnaire Study" instead of the current online study. This study has different procedures and a separate "Information for Research Participants. Instructions for returning the completed questionnaire are provided on the questionnaire cover page.

PARTICIPATION: Research participation is entirely voluntary. You can choose to not participate or to withdraw from the research by not finishing the questionnaire at any time without any negative consequence. Each person, however, may only participate in any HRG Well-Being Project ONE TIME only, choosing either the paper questionnaire study or the electronic online study.

THE PRIZE DRAWING: Anyone who completes the questionnaire can enter the weekly prize drawing for a \$30 gift certificate to a choice of over 100 stores, restaurants, movie theaters, and hotels including Macy's, Bloomingdale's, Saks Fifth Avenue, Bed Bath & Beyond, Staples, TJ Maxx, Sears, Bath & Body Works, AMC Theaters, Loews Theaters, Barnes and Noble, F.Y.E., Fandango, Red Lobster, Chili's, Boston Market, Hyatt Hotels, and many others. (See www.giftcertificates.com for a complete list.) One winner will be randomly selected each week on Monday from the group of people who have completed a questionnaire during the previous week.

ENTRY REQUIREMENTS: If just the Main Questionnaire (approximately 40 minutes) is completed, the respondent will get one entry into that week's prize drawing. If ALL questionnaires are completed (approximately 1 hour) then that respondent will get five entries for that week's prize drawing. A complete questionnaire is required in order to be entered into the prize drawing. A valid email address, initials of first and last name, and state/country of residence are required for entry into the prize drawing. Email addresses will not be used for any purpose other than announcing the results of the prize drawing. Email addresses will not be associated (physically or electronically) with the questionnaire responses. Each week, the winner's initials and state/country of residence will be announced on the project website and the winner will be notified by email. Additional details about the weekly prize drawings can be found at <http://wellbeingresearch.blogspot.com/2013/01/prizedrawinginfo.html>.

CONFIDENTIALITY: Participant names are not obtained for this research study. Email addresses, that may include names, will be kept separately from the questionnaires and it will not be possible to connect email addresses with questionnaire responses. In addition, ALL data will be kept confidential and will only be accessible to the research staff of The Harrell Research Group. Finally, any presentation or publication of the results of this research project will not identify specific participants or institutions. Only general statistics and

Instructions

GENERAL INSTRUCTIONS:

***We appreciate you being as truthful and open as possible when you are responding to the questions. Our research will only accurately inform a greater understanding of well-being if participants respond honestly.**

***Please answer ALL of the questions. We will let you know if you skipped a question and prompt you to respond.**

***You can bookmark your place using the red flag at the top right of the screen and come back to that place anytime within 7 days (from the same computer or device).**

***You can use the "Go Back" button at the bottom of any page to return to the previous page if you would like to review/check your responses.**

PART 1: BACKGROUND INFO

FIRST, JUST A BIT ABOUT YOU...

The purpose of this first section is to provide us with an overall description of the people who have participated in our research project. We appreciate your openness in sharing this information so that we can look at diverse experiences of well-being. Please remember that we have no way of identifying you personally.

1. Your Gender:

Male

☐

Female

☐

2. Your current age in years:

3a. Your Country of Birth:

3b. In what country was your mother born?

3c. In what country was your father born?

4. Your Country of Current Residence:

5. Length of time in your current country of residence (# of years):

6. Your current zip or postal code:

Which ONE of the following broad categories BEST describes your general racial-ethnic group identification at this time in your life?

- ☐ Native American/American Indian/First Nations
- ☐ North American White
- ☐ Other White (European, South African, Australian, Russian, etc.)
- ☐ White Multiethnic- Please specify:
- ☐ Multiracial/Multiethnic Minority- Please specify:
- ☐ Black African (continental)
- ☐ African/Black American
- ☐ Afro-Caribbean (Jamaican, Haitian, Trinidadian, etc.)
- ☐ Afro-Latino (Dominican, Puerto Rican, Cuban, etc.)
- ☐ Mexican/Mexican American
- ☐ Latino/Hispanic - Central or South American (El Salvador, Guatemala, Brazilian, Peruvian, Colombian, etc.)
- ☐ White Latino/Hispanic
- ☐ Middle Eastern/Arab descent
- ☐ Persian/Iranian descent
- ☐ Pacific Islander (Tongan, Samoan, etc.)
- ☐ South Asian/Indian/Pakistani
- ☐ Chinese/Chinese American
- ☐ Korean/Korean American
- ☐ Japanese/Japanese American
- ☐ Southeast Asian (Vietnamese, Cambodian, Laotian, etc.)
- ☐ Other- Please specify:

7. In your own words, please describe your racial-ethnic-cultural identity: (please be specific-examples: "Afro Brazilian born and raised in the United States", "Southern White American", "Chinese Canadian", "Multiracial with Black and Korean", "Iranian American identifying

primarily Jewish", "United States born White living in Japan for over 30 years and identifying primarily with Japanese culture" etc.) **NOTE: Please note that the survey software will not accept hyphens in your typed response.**

8a. Which one of the following BEST describes your general religious/spiritual affiliation at this time in your life?

- ☐ Jewish / Judaism
- ☐ Catholic / Catholicism
- ☐ Protestant Christianity (Methodist, Baptist, Lutheran, Episcopalian, etc.)
- ☐ Nondenominational or other Christian
- ☐ Unitarian, Universalist
- ☐ Muslim / Islam
- ☐ Buddhism
- ☐ Hinduism
- ☐ Ba'hai
- ☐ Indigenous / Culture-Centered Religious Belief System
- ☐ Religious Science
- ☐ New Age or New Thought Spirituality
- ☐ Wiccan or Other Pagan Religion
- ☐ Other Spiritual or Religious Belief System (please specify):
- ☐ Spiritual with no specific religious belief system
- ☐ Agnostic
- ☐ Atheist
- ☐ None of the Above

8b. In your own words, please more specifically describe your religious/spiritual identification and/or belief system (non-practicing cultural Jew, African Methodist Episcopal, Progressive Christianity, Eastern Orthodox Christianity, Sunni Muslim, etc.):

9. What is the highest level of education that you have achieved?

- ☐ Some high school or less
- ☐ High School Degree or Equivalent
- ☐ Community College, Vocational or Trade School Graduate (e.g., Cosmetology, Electrician, etc.)
- ☐ College/University Degree (B.A., B.S., etc.)
- ☐ Graduate or Professional Degree (e.g., MBA, M.D., Ph.D.)

10. Are you currently in school or a training program?

Yes, full-time

☐

Yes, part-time

☐

No

☐**11. Are you currently working for pay?**

- ☐ Working full-time for pay
- ☐ Working part-time for pay
- ☐ Not working for pay currently but looking for a job
- ☐ Not currently working for pay by choice

12. What is your profession, occupation, or vocation?**13. Which of the following BEST describes your relationship status over the PAST TWO WEEKS?**

- ☐ Not currently dating at all
- ☐ Dating or going out casually
- ☐ In an intimate relationship with a boyfriend or girlfriend
- ☐ In a permanent relationship with my life partner

14. Please check any or all of the following that apply to you:

- ☐ Never married
- ☐ Currently married
- ☐ Living together with my spouse or life partner
- ☐ Separated from my current spouse or life partner
- ☐ Divorced
- ☐ Widowed

15. Which of the following best describes your sexual orientation identity at this time?

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Gay or Lesbian (Homosexual)
- ☐ Questioning
- ☐ Other(please describe):

16. Are you currently a primary caregiver (physical, legal, financial responsibility) for an elderly person or dependent adult (older than 18 years)?

- ☐ Yes
☐ No

17a. Are you currently a parent or legal guardian of a child (birth-18 years)?

Yes
☐

No
☐

17b. How many children (birth-18 years old) currently live with you?

18. Which of the following best describes your financial situation at this time?

- ☐ My basic needs like food and shelter are not always met.
☐ My basic needs are met (food, shelter, clothing) but no extras
☐ I have everything I need and a few extras.
☐ I am able to purchase many of the things I want.
☐ Within limits, I am able to have luxury items like international vacations, new cars, etc.
☐ I can buy nearly anything I want, anytime I want.

In US dollars, what was your approximate annual household income during the past year?

- ☐ Less than \$25,000
☐ \$25,000-\$50,000
☐ \$50,000-\$100,000
☐ \$100,000-\$250,000
☐ \$250,000-\$500,000
☐ More than \$500,000

19. During the PAST TWO WEEKS, how much stress have you experienced?

Less than usual
☐

About the same as usual
☐

More than usual
☐

20a. During the PAST TWO WEEKS, have you been negatively affected by an illness or condition that interfered with your regular lifestyle?

Yes
☐

No
☐

20b. Which, if any, of the following health conditions have you experienced over the PAST TWO WEEKS? (check all that apply)

- ☐ Flu/Influenza or Severe Cold
- ☐ Moderate to Severe Allergic Reaction / Allergies
- ☐ Anemia
- ☐ Obesity
- ☐ Migraines or Chronic Headaches
- ☐ Chronic Back Pain
- ☐ Cut or Wound from an injury
- ☐ Concussion or other Head Injury
- ☐ Musculoskeletal Injury (broken bones, torn ligaments, sprains, dislocations, Carpal Tunnels, etc.)
- ☐ Gastrointestinal Problem (diarrhea, constipation, food poisoning, etc.)
- ☐ Hernia
- ☐ Appendicitis, Kidney Stones, or other acute health problem
- ☐ Pre-Diabetes or Insulin Resistance
- ☐ Diabetes
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol
- ☐ Heart / Cardiovascular Disease
- ☐ Depression, Anxiety, Phobia, or PTSD
- ☐ Adult ADHD
- ☐ Cerebrovascular Disease (Stroke, TIAs)
- ☐ Musculoskeletal Disease (Lupus, Fibromyalgia, etc.)
- ☐ Gastrointestinal Disease (Ulcerative Colitis, Irritable Bowel Syndrome, Crohn's Disease, etc.)
- ☐ Neurological Disease (Epilepsy, Parkinson's, Multiple Sclerosis, Huntington's Disease, etc.)
- ☐ Alzheimer's Disease or other Memory Problem
- ☐ Cancer, Malignant Tumor, or Blood Disease
- ☐ Endocrine or Thyroid Disease
- ☐ Asthma or Other Respiratory Disease
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse or Addiction
- ☐ Anorexia, Bulimia, or Binge Eating Disorder
- ☐ HIV / AIDS
- ☐ Epstein-Barr / Chronic Fatigue Syndrome
- ☐ Reproductive Problem
- ☐ Sleep Disorder
- ☐ Limited Mobility requiring an assistive device such as a walker or wheelchair
- ☐ Deafness or Hearing Problem
- ☐ Blindness or Vision Problem
- ☐ Other Physical or Mental Health Condition or Addiction that has been diagnosed by a health care professional
(please specify):

21. Finally, please feel free to indicate below any important aspect of your identity or background (relevant to your well-being) that we have not included in the questions so far:

PART 2: YOUR WELL-BEING

THE MAIN WELL-BEING QUESTIONNAIRE

We understand that well-being means different things to different people so please answer as openly and honestly as possible about your own experience. There is no "correct" way to have well-being! Using the dropdown menu for each item, please select the response that indicates how much each statement has been true for you DURING THE PAST TWO WEEKS, including today. This is the scale that you will see in the dropdown menu.

NEVER/NOT AT ALL= Not true for me during the past 2 weeks, not even one time

RARELY/A LITTLE= True for me only a few times during the past 2 weeks

SOMETIMES/SOMEWHAT= True for me about half the time

PRETTY OFTEN/MOSTLY= True for me most days during the past 2 weeks

VERY FREQUENTLY/VERY STRONGLY= True for me usually everyday

ALWAYS/EXTREMELY= True for me nearly all day everyday (USE THIS SPARINGLY!)

DOES NOT APPLY TO ME= This statement doesn't relate to my life at all

While we do provide a "Does not Apply" option, we ask that you **ONLY** use it for things that truly don't make sense for you. However, if it is something that just hasn't been true for you over the past two weeks, then the "Never" option would be more appropriate. *(Example: "I fed my bear chocolate cake". You would answer "DOES NOT APPLY" only if you DON'T actually have a bear. If you DO have a bear but would never feed her chocolate cake, then you would answer "NEVER/NOT AT ALL"-- even if feeding your bear chocolate cake is something that doesn't fit you at all).*

Finally, please answer ALL 160 questions in this section so that we have complete information about well-being for everyone who participates. Remember, FROM THIS SAME DEVICE (computer, tablet, smartphone), you can come back anytime over the next 7 days to complete the questionnaire wherever you left off (USE THE RED BOOKMARK FLAG IN THE TOP RIGHT CORNER TO MARK YOUR PLACE).

Thanks so much!!!

We TRULY appreciate your time and participation!

REMEMBER, answer each of the next 160 questions for what has been true for you over THE PAST 2 WEEKS only...

1. I was satisfied with how things were going in my life.

2. I felt strong and empowered.

3. I handled my daily challenges well, coped effectively with everyday stress/problems.

4. I felt like my life had meaning, like I'm here for a purpose.

5. I was creative or had good ideas.

6. I did something to help make the world a better place.

7. I felt caring and loving feelings towards the people closest to me.

8. I was able to relax or calm myself when I needed to.

9. There was someone I could trust with my most personal/private thoughts and feelings.

10. I was able to use or display my knowledge, skills, and/or talents.

11. I made good decisions.

12. I felt safe getting to and from the places I needed to go.

13. I felt physically healthy and strong enough to handle the demands of my daily activities.

14. There was someone who encouraged, supported, or motivated me.

15. I took time to “smell the roses”, really noticing and enjoying things from my senses (e.g., aromas, sounds, tastes).

16. I actively participated in an organization related to my culture or another community that is important to me.

17. I had positive interactions with people (neighbors, co-workers, salespersons, etc.).

18. I spent time in places with lots of grass, flowers, trees, clean rivers, lakes, or beaches, etc.

19. I spent time doing my hobbies, special projects, or other activities that I enjoy.

20. I did some type of physical exercise for fitness, strength, endurance, or fun.

21. I showed patience with a person or situation.

22. I was open to new things; willing to step out of my comfort zone.

23. I felt proud of my cultural heritage (or the history/background of another group in society important to my identity).

24. I was satisfied with my situation related to romance or intimacy.

25. I was comforted by the presence of a Higher Power/God in my life.

26. I had a positive event or activity to look forward to.

27. People in my neighborhood know each other and can depend on each other.

28. I felt safe from physical harm from people I know.

29. I felt compassion or sympathy for someone.

30. I was able to be myself, to be “real” with the people I care about (didn’t have to pretend or be fake).

31. I felt respected by others for my positive qualities or actions.

32. My faith or spirituality was strengthened through reading, classes, or discussions.

33. I felt like I was “home” when I was with people from my culture (or another group in society important to my identity).

34. I bounced back or recovered from any disappointments or bad things that happened.

35. I listened to what my body needed in terms of rest, water, food, etc.

36. There was plenty of open space in my community; it was not overcrowded by people or traffic.

37. My home country was strong and stable in terms of leadership and political matters.

38. My faith and spiritual beliefs were strong.

39. I had someone in my life who “has my back”, who is there for me when I need them.

40. I felt strongly and emotionally connected to my culture or another group in society that is important to me. (e.g., religious, disability, sexual orientation, military, large extended family, etc.) .

41. I gained a greater knowledge and understanding of a local, national, or global issue.

42. I was “moved” by creative expression, had a strong emotional connection or experience related to music, art, dance, etc.

43. I felt accepted and welcomed by people at my workplace, school, or other place where I spend a lot of time.

44. I felt joy and happiness inside.

45. I felt connected to a purpose larger than my personal life.

46. I was able to relieve (or didn't experience any) symptoms of stress in my body (e.g., neck/back tension, headache, stomachache, dizziness, trouble breathing, etc.).

47. I supported someone in getting through a difficult situation.

48. I was satisfied with my sexual functioning and activity.

49. I had a network of people available to me that were important sources of help and support in my life.

50. I felt really "alive", present and engaged with the here-and-now moments of my life.

51. I felt good about the direction my home country was going in.

52. I was a leader or took initiative to start some action for change in my community or organization.

53. I had a strong awareness of how I was feeling and what I needed.

54. I was confident in myself; my self-esteem was high.

55. The water, electricity, and plumbing worked fine where I was living.

56. I felt loved by and/or in a close relationship with a Higher Power/God in my life.

57. I felt a strong sense of gratitude, an appreciation for both the ups and downs in my life.

58. I effectively managed any physical pain or health problems I was having.

59. I did something to try to resolve a conflict or improve a relationship.

60. I enjoyed special time with a pet or other animal.

61. I felt at peace inside of myself.

62. I worked together with others on an issue of mutual concern in my community, workplace, school, or other setting.

63. I felt guided by a vision or mission for my life.

64. I observed or learned something positive about my culture (or another group in society that is very important to my identity).

65. I showed kindness, did something nice for someone.

66. I felt like things were improving in my life.

67. I avoided things that are harmful or dangerous to my health (e.g., cigarettes, excessive alcohol, illegal drugs, driving recklessly, etc.).

68. How I lived my daily life was consistent with my spiritual or religious beliefs.

69. I enjoyed spending time in my neighborhood or local community.

70. I felt connected to the rhythms and patterns of nature (e.g., animals, trees, oceans, stars, mountains, or other living things).

71. I felt good about how I was fulfilling my role in my family, culture, or in another group in society most important to me.

72. I did or said something to lift someone's spirits.

73. I felt safe from gang violence, terrorism, police, (or military) violence.

74. I had an amazing or "peak" experience (e.g., heightened awareness, awe, intense connection with another person, a creative burst, a revelation).

75. I did a good job at work, school, or with my other responsibilities.

76. I spent time in meditation, personal reflection, or deep contemplation.

77. I intervened or stood up for someone in a situation involving injustice or unfairness.

78. I felt a strong sense of belonging in my neighborhood (e.g., it felt like "home" to me).

79. I assisted someone in need.

80. I enjoyed expressing and sharing my spirituality with other people or in a faith community.

81. I gave good advice or guidance to someone.

82. I lived with integrity, was true to myself and my values ("walked my talk").

83. My living environment was generally safe and healthy (e.g., free from mold, industrial pollution, dangerous chemicals, rodents, broken glass, peeling paint, etc.).

84. I felt supported by people at my workplace, school, or other place where I spend a lot of time.

85. I felt a greater understanding of myself. (e.g., why I am the way that I am; why I do the things that I do).

86. I felt safe from hate crimes, violence, or discrimination based on something about me like my race, religion, gender, sexual orientation, disability, etc.

87. I had companionship or a good social life, people to talk to or do things with.

88. The beauty and miracles of nature made me feel closer to a Higher Power/God.

89. I felt safe from sexual violence or exploitation.

90. I was “in the zone”, got totally lost or immersed in an activity that I enjoyed.

91. I felt better about something that had been bothering me.

92. I received valuable counsel from a minister, rabbi, imam, priest, guru, pastor, or other religious leader.

93. I stopped to pay attention to what I was feeling emotionally and/or physically.

94. I had a strong sense of my values, what is most important to me.

95. My spiritual/religious beliefs and activities gave me strength and guidance through the challenges I faced.

96. I got along well with family members.

97. I was guided positively by my intuition about things.

98. The place where I live was mostly free from very loud noises such as traffic, trains, gunshots, sirens, etc.

99. I felt positively connected with the soul or spirit of another person (living or deceased).

100. I felt accepted by many people in my culture (or another group in society that is very important to me).

101. I had a feeling of wisdom, insight or understanding about life.

102. My neighborhood or local community was an important part of my life.

103. I felt a lot of national pride in my home country.

104. I resisted temptation; said “no” to something that would have been bad for me.

105. I felt connected to all of humanity regardless of race, nationality, social class, etc.

106. I expressed gratitude or appreciation to someone.

107. I participated in or contributed to positive change on a social justice issue or cause.

108. I motivated, encouraged, or cheered someone on.

109. I displayed my identification with my culture or other important identity group (symbols, clothing, language, artwork, home decor, bumper stickers, etc.).

110. I felt safe from threats, verbal abuse, emotional abuse, or stalking.

111. My basic needs were met (e.g., shelter, food, clothing).

112. I felt a clear awareness of who I am, my identity.

113. I helped someone understand or learn something.

114. I volunteered my time in the service of people in need, animals, the environment, or another cause important to me.

115. I was valued and respected at my workplace, school, or other place where I spend a lot of time.

116. Someone prayed or said blessings for me.

117. I got enough hours of peaceful, uninterrupted sleep.

118. I made sure I was informed about things happening in my neighborhood community.

119. I felt good about my friendships.

120. I was growing and learning important life lessons.

121. I felt secure and grounded by my roots in my culture or another group in society important to my identity.

122. I looked forward to being at work, school, or another place where I spend a lot of time (other than where I live).

123. I learned something new, became more knowledgeable.

124. I extended forgiveness or let go of negative feelings that I was having toward someone.

125. I did something to move my life forward or head in the right direction.

126. I felt committed to making my home country a better place.

127. I was aware of the connection between my mind, my emotions, and what was going on in my body.

128. I felt loved.

129. I felt safe in the neighborhood where I live.

130. I spent time praying, reading religious/spiritual books, or listening to spiritual music.

131. I was productive, got things done.

132. I felt that my family was well-respected in our cultural community or another important community.

133. I was becoming a better person; something about me was changing for the good.

134. I felt like someone really understands me and knows me well.

135. I felt inspired or excited about something.

136. My loved ones were safe from violence, abuse, or harassment.

137. Something good happened or turned out the way I wanted it to.

138. I had smiles, fun, and laughter in my life.

139. I got plenty of fresh outdoor air.

140. I felt good putting the needs of my family, culture, or other group in society (most important to me) above my own personal needs and wants.

141. I made progress dealing with a problem or getting rid of a bad habit.

142. I followed through on something, kept my word, or did what I said I would do.

143. I felt hopeful and optimistic.

144. I took good care of my health.

145. I witnessed or experienced spiritual healing.

146. I did something with excellence, something to be proud of.

147. I was able to purchase most (or all) of the material things that I wanted.

148. I did things during my free time (e.g., movies, music, books, websites, social activities) that reflected my culture or another group in society very important to my identity.

149. I was able to make something positive out of a negative situation.

150. Buildings and public areas in my neighborhood were kept in good condition.

151. I had a positive attitude, was in a good mood.

152. I enjoyed the physical comforts of home like my bed, my kitchen, or my bathroom.

153. I felt a strong sense of belonging at my workplace, school, or another place where I spend a lot of time.

154. I felt comfortable with my sexuality.

155. I had positive feelings about my home country.

156. I had enough privacy where I was living.

157. I took special care of my grooming or physical appearance (e.g., hair, clothing, face, body).

158. I had self-control.

159. I was a respectable member of my culture (or another group in society that I most identify with) and represented it well.

160. I ate mostly healthy and nutritious foods.

Next, please indicate the importance of each of the following in determining your well-being at this time in your life.

Specifically:

- If what is going on in that area, positive or negative, affects how satisfied you are with your life then it would be considered **MORE important** to your well-being.
- If what is going on in that area of your life doesn't make much of a difference to how satisfied you are with your life then it would be considered **LESS important** to your well-being.

My daily activities and achievements

Not at all important



A Little Important



Somewhat Important



Very Important



Doing good things for other people.

Not at all important



A Little Important



Somewhat Important



Very Important



Having positive emotions and feelings.

Not at all important



A Little Important



Somewhat Important



Very Important



Having a sense of belonging to a strong community (e.g., workplace, neighborhood, school, or other organization).

Not at all important



A Little Important



Somewhat Important



Very Important



Having strong self-awareness-- being aware of who I am, what I am feeling, sensing, thinking.

Not at all important



A Little Important



Somewhat Important



Very Important



My physical health and functioning.

Not at all important



A Little Important



Somewhat Important



Very Important

**My spirituality or religious experience.**

Not at all important



A Little Important



Somewhat Important



Very Important

**Having a sense of meaning & purpose.**

Not at all important



A Little Important



Somewhat Important



Very Important

**Being safe from harm or danger.**

Not at all important



A Little Important



Somewhat Important



Very Important

**Improving myself and making progress on changes I'm working on.**

Not at all important



A Little Important



Somewhat Important



Very Important

**Participating in positive social/community change.**

Not at all important



A Little Important



Somewhat Important



Very Important

**A strong identity and connection to my culture (or another group in society central to my identity such as my religion, sexual orientation, or ability/disability status).**

Not at all important



A Little Important



Somewhat Important



Very Important

**The physical environment where I am living.**

Not at all important



A Little Important



Somewhat Important



Very Important

**The quality of my relationships with the people closest to me.**

Not at all important



A Little Important



Somewhat Important



Very Important

**How things are going in the country I consider home.**

Not at all important



A Little Important



Somewhat Important



Very Important



Finally, please click the box next to the **FIVE (5) MOST IMPORTANT** areas for determining your well-being at this time in your life.

- ☐ My daily activities and achievements
- ☐ Doing good things for other people
- ☐ Having positive emotions and feelings
- ☐ My physical health and functioning
- ☐ My spirituality or religious experience
- ☐ Having a sense of meaning & purpose
- ☐ Being safe from harm or danger
- ☐ Improving myself and my life
- ☐ Participating in positive social/community change
- ☐ A strong identity and connection to my culture (or another group in Society central to my identity such as religion, sexual orientation, ability/disability status)
- ☐ Having a strong awareness of myself, my thoughts and feelings
- ☐ The quality of my relationships with the people closest to me
- ☐ How things are going in my home country
- ☐ My physical living environment
- ☐ Having a strong sense of belonging and connection to my neighborhood, work, or school community

Stop or Continue

Thank you for completing our Main Questionnaire. You can choose to stop now and receive 1 entry into THIS WEEK'S PRIZE DRAWING for a \$30 Gift Certificate to your choice of over 100 retailers including Bloomingdale's, Macy's, Bed Bath & Beyond, Barnes & Noble, Bath & Body Works, K-Mart, Chili's, Red Lobster, Boston Market, AMC Theaters, Hyatt Hotels and more!

OR...

You can CONTINUE for about another 20 minutes to help us validate our Well-Being Questionnaire by answering some additional questions about how you have been doing lately. If you choose to participate in our Full Study, you will GET FIVE (YES 5!) ENTRIES into this week's Prize Drawing which will greatly increase your chance of winning!

What would you like to do?

- ☐ Stop now and get one (1) entry into this week's Prize Drawing
- ☐ Stop now but don't enter me in the Prize Drawing.
- ☐ Continue for another 20 minutes and get FIVE (5) entries into this week's Prize Drawing.

Thank you again for completing our Main Well-Being Questionnaire and contributing to the development of a broader understanding of well-being and how to measure it!

Please provide the information requested below in order to be entered into our weekly \$30 gift certificate prize drawing. We will post the results of the prize drawing on our website (www.wellbeingresearch.net) and email you if you are a winner! Good luck!

Your state and country of residence:

Initials of your first and last name:

Your email address:

SWLQ

Thank you for giving us a bit more of your time!

Some of the remaining questions may seem repetitive but this is important for us to be able to fully understand well-being and the best way to measure it. We appreciate your sticking with us and your willingness to answer each question as openly and honestly as you can!

Below are five general statements about your life that you might agree or disagree with. Using the dropdown menu, please indicate how much you agree or disagree with each item by highlighting the appropriate response. Please reflect for a moment on each item and respond based on your assessment at this time in your life.

1. In most ways my life is close to my ideal.

2. The conditions of my life are excellent.

3. I am satisfied with my life.

4. So far I have gotten the important things I want in life.

5. If I could live my life over, I would change almost nothing.

BADD

The following statements are about different ways that people experience distress or problems in their lives. Please highlight the response in the dropdown menu that best indicates how frequently you have felt that way over the PAST TWO WEEKS.

NEVER true for me (*Not at all during the past two weeks.*) or **DOES NOT APPLY**

RARELY true for me (*Just a few times; once or twice a week.*)

SOMETIMES true for me (*About half the time or several days during the past two weeks.*)

FREQUENTLY true for me (*Most of the time or most days during the past two weeks.*)

(ALMOST) ALWAYS true for me (*Everyday or nearly all the time during the past two weeks.*)

1. I felt overwhelmed by the stress in my life.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

2. I felt hopeless or trapped, unable to find relief.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

3. I felt lost, like I had no direction or purpose.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

4. I was really tired, worn out, exhausted.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

5. I felt confused, like I didn't know what to do or what I want.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

6. I was irritable, in a bad mood, or just felt angry.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

7. I felt afraid; there was danger or threats.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

8. I felt insecure and inferior to other people.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

9. I didn't care about much of anything, nothing really mattered

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

10. I felt guilty, ashamed, or bad about myself.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

11. I felt like life was really unfair to me.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

12. I felt like there was nothing to look forward to.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

13. I engaged in behaviors that could have negative consequences (risky sex, gambling, financial debts, drugs or alcohol, criminal activities).

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

14. I had problems getting along with other people at work, school, or in other settings (stores, social situations, etc.).

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

15. I didn't take care of my responsibilities at home, work, or school.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

16. I felt isolated and disconnected from other people.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

17. I couldn't stop worrying about things.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

18. I made bad choices or didn't use good judgment.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

19. There was trouble in my close relationships (family, friends, or romantic).

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

20. I felt out of control; like I couldn't control myself in things I said or did.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

21. There was violence in my life that touched me or my loved ones.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

22. I felt like a failure or a loser.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

23. My emotions or behavior interfered with my job, school, relationships, or other activities.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

24. I did things that I felt bad about.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

25. I had sleep problems like insomnia or nightmares.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

26. I had feelings of intense panic.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

27. There were disturbing thoughts or images I couldn't get out of my mind.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

28. I felt like I was going crazy, like I was losing my mind.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

29. I felt really sad or depressed.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

30. I did things that were messing up my life.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

31. I felt on edge, nervous, had a lot of anxiety.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

32. I had trouble concentrating, focusing, or remembering things.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

33. I felt like I might have serious emotional problems.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

34. I felt intense rage or had temper outbursts, yelling and screaming at others.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

35. I had crying spells I couldn't stop.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

36. I experienced physical changes such as my heart beating really fast, headaches, rashes, stomachaches, dizziness, or shortness of breath.

Never Rarely Sometimes Frequently Always

☐ ☐ ☐ ☐ ☐

Spane and Flourishing

Again, think about what you have been feeling and experiencing for THE PAST TWO WEEKS. For each item, please choose the response that indicates how frequently each item describes your experience over THE PAST TWO WEEKS.

1. Positive

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

2. Negative

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

3. Good

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

4. Bad

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

5. Pleasant

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

6. Unpleasant

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

7. Happy

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

8. Sad

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

9. Afraid

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

10. Joyful

Very Rarely or Never
☐

Rarely
☐

Sometimes
☐

Often
☐

Very Often or Always
☐

11. Angry

Very Rarely or Never



Rarely



Sometimes



Often



Very Often or Always

**12. Contented**

Very Rarely or Never



Rarely



Sometimes



Often



Very Often or Always



Below are eight general statements about your life that you might agree or disagree with. Using the dropdown menu, please indicate how much you agree or disagree with each item by highlighting the appropriate response. Please reflect for a moment on each item and then answer based on what is genuinely true for you at this time in your life.

1. I lead a purposeful and meaningful life.

2. My social relationships are supportive and rewarding.

3. I am engaged and interested in my daily activities.

4. I actively contribute to the happiness and well-being of others.

5. I am competent and capable in the activities that are important to me.

6. I am a good person and live a good life.

7. I am optimistic about my future.

8. People respect me.

Personal Well-Being Index (PWI)

The following questions ask how satisfied you feel at this time in your life, on a scale from zero to 10. Zero means you feel completely dissatisfied. 10 means you feel completely satisfied. And the middle of the scale is 5, which means you feel neutral, neither satisfied nor dissatisfied.

Completely		Neutral								Completely	
Dissatisfied										Satisfied	
0	1	2	3	4	5	6	7	8	9	10	

During the **PAST TWO WEEKS**, HOW SATISFIED HAVE YOU BEEN with each of the following areas of your life?

1. your standard of living?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. your health?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. what you are achieving in your life?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. your personal relationships?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. how safe you feel?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. feeling part of your community?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. your future security?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. your spirituality or religion?

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. "Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole ?"

0-Completely Dissatisfied	1	2	3	4	5- Neutral	6	7	8	9	10-Completely Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Questionnaire for Eudaimonic Well-Being

This section contains a series of statements that describe people and their lives. Read each statement carefully and think about YOUR life and how you feel about it at this time. Next, indicate the extent to which you agree or disagree with the statement by highlighting your response in the dropdown menu. Try to respond to each statement according to how things are actually going, rather than how you might wish them to be. Please use the following scale when responding to each statement:

Strongly Disagree 0 1 2 3 4 Strongly Agree

1. I find I get intensely involved in many of the things I do each day.

Strongly Disagree - 0	1	2	3	4 - Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I believe I have discovered who I really am.

Strongly Disagree - 0	1	2	3	4 - Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I think it would be ideal if things came easily to me in my life.

Strongly Disagree - 0	1	2	3	4 - Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. My life is centered around a set of core beliefs that give meaning to my life.

Strongly Disagree - 0	1	2	3	4 - Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. It is more important that I really enjoy what I do than that other people are impressed by it.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

6. I believe I know what my best potentials are and I try to develop them whenever possible.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

7. Other people usually know better what would be good for me to do than I know myself.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

8. I feel best when I'm doing something worth investing a great deal of effort in.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

9. I can say that I have found my purpose in life.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

10. If I did not find what I was doing rewarding for me, I do not think I could continue doing it.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

11. As yet, I've not figured out what to do with my life.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

12. I can't understand why some people want to work so hard on the things that they do.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

13. I believe it is important to know how what I'm doing fits with purposes worth pursuing.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

14. I usually know what I should do because some actions just feel right to me.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

15. When I engage in activities that involve my best potentials, I have this sense of really being alive.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

16. I am confused about what my talents really are.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

17. I find a lot of the things I do are personally expressive for me.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

18. It is important to me that I feel fulfilled by the activities that I engage in.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

19. If something is really difficult, it probably isn't worth doing.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

20. I find it hard to get really invested in the things that I do.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

21. I believe I know what I was meant to do in life.

Strongly Disagree - 0 1 2 3 4 - Strongly Agree

☐ ☐ ☐ ☐ ☐

Marlowe-Crowne Social Desirability Scale

Please indicate if each of these statements is generally true or false for you.

1. It is sometimes hard for me to go on with my work if I am not encouraged.

☐ True ☐ False

2. I sometimes feel resentful when I don't get my way.

☐ True ☐ False

3. On a few occasions, I have given up doing something because I thought too little of my ability.

☐ True ☐ False

4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

☐ True ☐ False

5. No matter who I'm talking to I'm always a good listener.

☐ True ☐ False

6. There have been occasions when I took advantage of someone.

☐ True ☐ False

10. I have never been irked when people expressed ideas very different from my own.

☐ True ☐ False

7. I'm always willing to admit it when I make a mistake.

☐ True ☐ False

8. I sometimes try to get even rather than forgive and forget.

☐ True ☐ False

9. I am always courteous, even to people who are disagreeable.

☐ True ☐ False

11. There have been times when I was quite jealous of the good fortune of others.

☐ True ☐ False

12. I am sometimes irritated by people who ask favors of me.

☐ True ☐ False

13. I have never deliberately said something that hurt someone's feelings.

☐ True ☐ False

Full Study Prize Drawing Entry

Thank you SO MUCH for participating in the full study and contributing to the

development of a broader understanding of well-being and how to measure it! Please provide the information requested below in order to get your FIVE entries into this week's Prize Drawing for 5 chances to win a \$30 Gift Certificate to your choice of over 100 stores, restaurants, and other retailers. We will post the result of the prize drawing on our website and email you if are a winner. Good luck!

Your state and country of residence:

Initials of your first and last name:

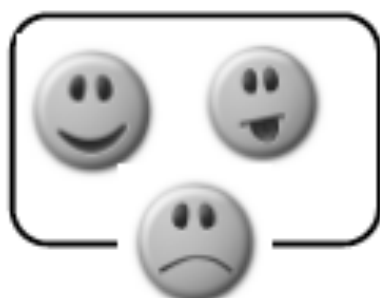
Your email address:

Thank You

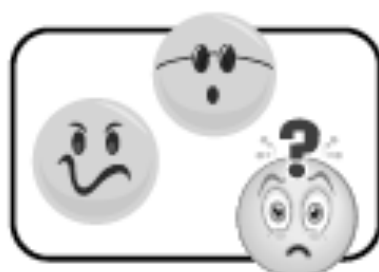
Once again, thank you so much for your time and contribution to our Well-Being Research Project! Remember, you can check our website (www.wellbeingresearch.net) periodically if you are interested in project updates!

-Dr. Shelly Harrell and The Harrell Research Group

APPENDIX C:
Recruitment Flyers



How have YOU been doing lately?



We'd like to know!

The Harrell Research Group at Pepperdine University is conducting a research study to better understand wellness and well-being...and we need your HELP!



**Participate to WIN A \$30 GIFT CERTIFICATE
in our WEEKLY PRIZE DRAWING!**

Scan the QR Code
below to do the
questionnaire NOW!



It is EASY to do our online questionnaire from your desktop, laptop, tablet or smartphone! OR you can print it out from our website!

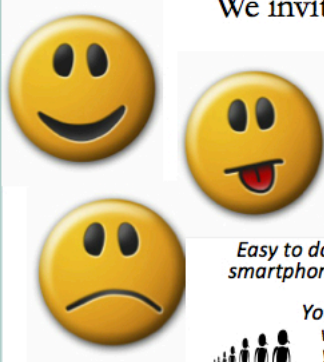
You can do the questionnaire when you are somewhere just waiting for something! ...like while you're waiting in line at the store, at the auto shop, at the doctor's office, at the hair salon or barber shop!

Participate anywhere, anytime!



Visit us at www.wellbeingresearch.net for more info!

How have **YOU** been doing lately?



We invite you to participate in The Well-Being Project, a research study to better understand wellness and well-being among adults 18 years or older

Complete our questionnaire for a chance to
WIN A \$30 GIFT CERTIFICATE
 in our **WEEKLY PRIZE DRAWINGS!!!!**

Easy to do online from your desktop, laptop, tablet or smartphone! OR you can print it out from our website!



You can do the questionnaire when you are somewhere just waiting for something! ...like while you're waiting in line at the store, at the auto shop, at the doctor's office, at the hair salon or barber shop!

Participate anywhere, anytime!

Scan the QR Code below
 to do our questionnaire
NOW!



For more information, please visit us at www.wellbeingresearch.net

(This study is being conducted by the Harrell Research Group
 at Pepperdine University's Graduate School of Education and Psychology)

APPENDIX D:
GPS IRB Approval Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 14, 2013

Dr. Shelly
Harrell 6100
Center Drive
Los Angeles, CA 90045

Protocol #: P0313F07

Project Title: Psychometric Validation of the Multidimensional Well-Being Assessment (MWA) and Broad Assessment of Distress and Dysfunction (BADD) in Diverse Populations

Dear Dr. Harrell,

Thank you for submitting your application, Psychometric Validation of the Multidimensional Well-Being Assessment (MWA) and Broad Assessment of Distress and Dysfunction (BADD) in Diverse Populations, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Approval**. The IRB approval begins today, **May 14, 2013**, and terminates on **May 14, 2014**. In addition, your application to waive documentation of informed consent, as indicated in your **Application for Waiver or Alteration of Informed Consent Procedures** form has been **approved**.

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For **any** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **May 14, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence

6100 Center Drive, Los Angeles, California 90045 ■ 310-568-5600

related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,



Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University
Graduate School of Education & Psychology
6100 Center Dr. 5th Floor
Los Angeles, CA 90045
Doug.Leigh@pepperdine.edu
W: 310-568-2389
F: 310-568-5755

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs

